The Modern Hospital

SEPTEMBER 1953

The Clinical Center Didn't Just Grow • Essentials of a Good Tissue Committee • Administrator Speaks Frankly to a Hospital Supply Salesman • Nurse Intern Plan • Theft Control • Depreciation Accounting • Admissions Clerks • Laundry Costs

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New planning!
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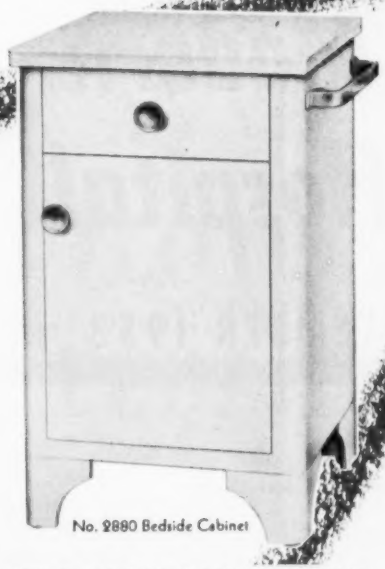

No. 2880 Bedside Cabinet

NEW PLANNING MADE IT POSSIBLE!

In these days of rising material and labor costs, most companies are doing well merely to hold their price line. But we at "Brooklyn" wondered whether a fresh view of the production situation wouldn't result in something more than "just as good as someone else" So we decided to pitch in and test our ideas on the versatile little bedside cabinet and find out once and for all what could and what couldn't be done. To push the cost way down and still maintain every last inch of our reputation for solid workmanship - - - that was the puzzle for planning to solve. And we did it - - - **WITHOUT THE SMALLEST SACRIFICE OF QUALITY!**

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No. 2880 Bedside Cabinet, exactly as illustrated.

No. [illegible]—same as No. 2880, but with molded rubber top instead of enameled steel.

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No. 2883—same as No. 2880, but with stainless steel top instead of enameled steel.

ALSO AVAILABLE

1. Swinging basin ring for above cabinets.
2. Porcelain enamel basin for above cabinets.
3. Stainless steel basin for above cabinets.
4. Set of four 2-inch casters installed.

QUALITY THROUGHOUT!

1. **Heavy gauge bonderized steel** throughout (Cabinet weighs approximately 50 lbs. net.)
2. **Rounded-corner** cabinet construction.
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6. **Choice of color.** White will be supplied unless ivory, brown, or green is specified Grained finishes available at slight additional cost.
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8. Both the door and drawer front are **double-walled** and **fit flush** to cabinet face.
9. Door is hung on **fully concealed hinges** and is fitted with noiseless **rubber friction catch and bumpers**
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11. **Ventilating louvers** at rear of cabinet.
12. Cabinet is mounted on **rust-proof, non-marking glides.**
13. Equipped with a built-in fitting for mounting a swinging basin ring whenever desired.

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The Modern Hospital

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AMONG THE AUTHORS


Celeste K. Kemler

Celeste K. Kemler, who speaks up frankly on the delicate subject of the relationship between administrators and hospital supply salesmen (*p. 64*), is administrator of the Valley View Hospital at Ada, Okla. A native of Iowa, Mrs. Kemler attended Iowa State College and entered the hospital field as a nurse and nurse executive. She did administrative work in Iowa hospitals for several years before moving to Oklahoma in 1946. She is a past president and a member of the board of directors of the Oklahoma State Hospital Association.


Dr. A. D. Rubenstein

Dr. A. Daniel Rubenstein, director of the division of hospitals of the Massachusetts Department of Public Health, is a graduate of Boston University School of Medicine. He has been associated with the state health department since he finished serving internship and residency appointments at Boston hospitals in 1937, having been epidemiologist and district health officer before entering the hospital division. Dr. Rubenstein has a master's degree in public health from Harvard University and is assistant professor of epidemiology there.


Theodore W. Fabisak

Theodore W. Fabisak, co-author with Dr. Rubenstein of the article on records on page 68, is senior accountant for the Massachusetts Department of Public Health. In this position, he supervises contractual relations between hospitals and Blue Cross, and he was recently appointed commissioner of hospital and medical insurance by the governor of Massachusetts. Mr. Fabisak is a graduate of the Bentley School of Accounting and Finance and has done graduate work in accounting and public health statistics. In 1949, he was appointed the first executive director of the Massachusetts Hospital Association.


Raymond G. Bodwell

Raymond G. Bodwell is now consultant to the Huron Road Hospital, East Cleveland, Ohio, where he was administrator for 18 years, notwithstanding the fact that he accepted the appointment for only a six-month period in 1935, when the hospital's board of trustees asked him to finish and open a new building then nearing completion. Mr. Bodwell had nursed the project along as vice president of the construction company that was handling the general contract for the building. Previously, he had supervised construction of numerous military, industrial, and public buildings, including a number of hospitals in the Cleveland area. In the hospital field, Mr. Bodwell has been president of the Cleveland Hospital Council, a trustee of the Ohio Hospital Association, and is a member of the A.C.H.A.


Hulda Merkel

Hulda Merkel, co-author with Mr. Bodwell of the article on page 66, is director of the school of nursing at Huron Road Hospital. A graduate of the Bolton School of Nursing at Western Reserve University, Mrs. Merkel has been a staff nurse, public health nurse, nurse executive and nursing teacher, mostly in the Cleveland area, for a number of years. She has been active in nursing and nursing education associations, and is presently vice president of the Ohio State League of Nursing Education.

in hospitals everywhere . . .

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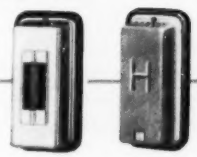

St. Patrick Hospital, Missoula, Mont. H. E. Kirkemo, architect, Missoula; D. C. Griffen, mechanical engineer, Seattle; Missoula Hardware & Plumbing Co., mechanical contractors, Missoula.

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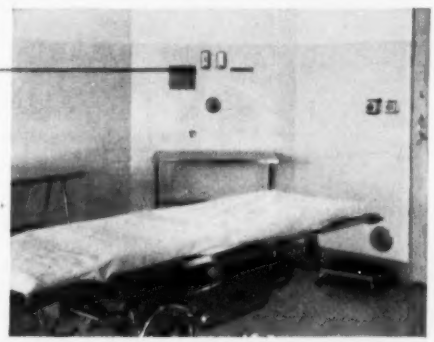

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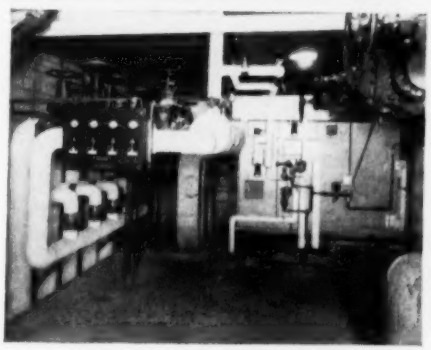

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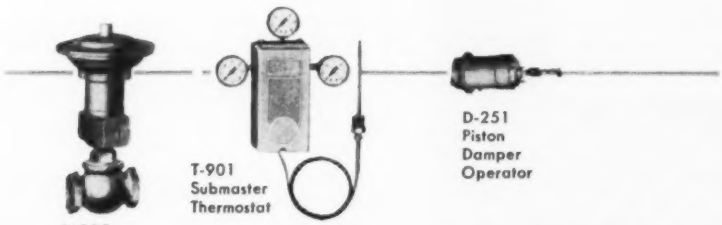

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T-901 Submaster Thermostat

D-251 Piston Damper Operator

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Roving Reporter

While Medical Auditing

What better roving reporter than a roving medical auditor! Dr. Lucius W. Johnson inspected hospitals for the American College of Surgeons after his retirement from an admiralship in the navy. Now he is an independent hospital consultant, veering strongly in the direction of medical audits. Dr. Johnson calls the knowing comments that follow: "Reverie While Medical Auditing."

• • •

"Kick him out!" The doctor who signed out a patient in this way was irritated and imprudent, but he was also a brave and honest one. When I alluded to it while making my report before the medical staff, he stood up and said he was the one who had written it. Then he told an amusing tale about his relations with the difficult patient. But just suppose that patient had sued the hospital and the doctor for cruel and incompetent treatment. The record would have been subpoenaed and shown to the judge and the jury. Whew!

• • •

"This is the finest hospital in this part of the state. Just look at all the stainless steel equipment in our kitchen, and our new Hubbard tank." But the food from that glittering kitchen was what my wife calls "just dried-up steam-table stuff." It reminded me of the song, popular a few years ago, "It ain't necessarily so." The Hubbard tank still shone because it had never been used. No physician or technician in the place knew what it could do or how to use it.

As a showpiece, to impress uncritical and uninformed visitors, however, it was probably worth what it cost. When the budget committee of the county supervisors visited the hospital each year, this glittering gadget convinced them that even larger appropriations were justified.

• • •

"A critic is probably a necessary evil," a hospital administrator told me, when I was in a position to criticize his work. After a pause for emphasis he continued, "But if he's smart enough to be any good as a critic, he'll know that he shouldn't expect to have any friends among the group he criticizes."

There is so much of truth, common sense and human nature in that remark that the one who made it has naturally forged to the front in the hospital world. Dr. Samuel Johnson accused a critic of having ants in his pants. When Charlie McCarthy criticized his favorite blonde she said he had termites in his hat. Sensitive people should not work in this field. The auditor quickly learns not to accept any hospitality until his report is made.

When I was visiting hospitals for the American College of Surgeons a disgruntled administrator expressed a dim view of the whole outfit. "We spent a lot of time with your representative. We showed him everything, even gave him a good lunch. Then the college said we weren't qualified to train residents. What kind of phony treatment is that?" The lesson was obvious—no approval, no lunch.

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SURGICAL DRESSINGS DIVISION

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"Trusteeitis"—this unhappy condition develops when a governing board goes to a lot of trouble to choose a well qualified administrator and then doesn't give him a chance to do the stuff he has been trained for. They give him no opportunity to establish his own policies or to exercise the authority that he must have if he is to earn the respect and confidence of those whose work he must direct.

• • •

This medical staff is making a really sincere effort to live up to the standards it professes. It had long been the practice for members to come to the monthly medical staff meetings, sign the register, and then depart. This boosted the attendance record without taking too much time from other activities. But the new chief of staff put through a rule that those who left before the end of the meeting could not vote at staff elections. The reasoning was that if they did not stay for the whole meeting they could not be sufficiently informed about hospital affairs, also about the qualities and abilities of other members.

Through the joint conference committee this was communicated to the trustees, who gave hearty endorsement. The view was expressed that such evidence of high moral and ethical ideals had earned the enthusiastic backing of the trustees in anything they might want to do to win accreditation.

• • •

The medical audit would be made so much simpler, so much less costly, if medical staffs would do two things:

1. Adopt minimum standards for clinical records.
2. Require each staff member to keep his records up to the standard.

• • •

The idea held by many persons—that a low death rate is evidence of a good hospital—is full of holes. There are two hospitals in this medium-sized city. Hospital A points with pride to its low death rate, but does some dubious things to keep it down. Rumor says that serious accident cases are sometimes held in the emergency room, with limited facilities, and then listed as D. O. A. Some of the staff complain that, while there is always a bed for simple elective surgery, the word is likely to be, "So sorry, no bed," when a gravely ill patient seeks admission.

Hospital B is preferred by the clinic group, into whose hands most of the more serious cases come. Naturally, it has the higher death rate. Teaching hospitals, which welcome patients with unusual and dangerous illnesses, often have a high rate, because the ablest practitioners in the community like to work there. Psychiatrists, dermatologists, allergists and plastic surgeons enjoy a death rate close to zero.

• • •

"The progress notes are the heart of the record. In them are found the effects of the treatment and the progress toward recovery." How often have we heard this? But so often, the only clue to the patient's progress must be picked out of the nurses' notes. Even "Disch. today" doesn't give a very substantial guide to the patient's progress.

• • •

Never have I heard, or read, adequate appreciation of the public relations value of the audit. The news that it is going on is soon spread through the community, offering a chance for press interviews with the auditor. This is an opening wedge for chances to talk before service clubs, chambers of commerce, or parent-teacher groups.

There the problems of the hospital can be set forth in a sympathetic manner before the leaders of the community thought. Trustees have stated that this publicity changed the cost of the audit into an investment in good will.

• • •

That man who introduced me when I talked before the chamber of commerce luncheon spoke of me as an "expert." That is one of the most versatile words in our American language. It is a word to conjure with, for it has a different meaning for your every mood. One of the oldest meanings is that an expert is a fellow who is a long way from home. I can qualify in that, for they brought me 1100 miles this time, and it may be a record of some kind.

A less complimentary definition is that an expert is one who can neither ask nor answer a simple question. Maybe that fits too, because during that question-and-answer session with the P.T.A. both sides had trouble in putting vague ideas into sentences that the other could understand. Those words charged with emotion kept creeping in and obscuring practical meanings.

Then there is the definition that an expert is one who can take something you already know and make it confusing. We have all seen examples of this in hospital conventions, especially when personnel relations are under discussion. Lastly, there is the definition that an expert is one who can tell you how to do a thing and then tell you why it didn't work. That really fits. And my legal friend says that anybody who gets $50 a day is automatically an expert, and that fits too. But still I wonder just what he meant when he called me an expert.

• • •

Before there is agreement on making an audit, the hospital group should clearly understand these three strikes against it:

1. The audit is expensive.
2. The findings and recommendations may be embarrassing, even humiliating, and perhaps to important persons.
3. The cost is wasted unless the recommendations are firmly and fairly carried out.

• • •

"How can we communicate our goals, our efforts, our problems to the public?" Thus the speakers wail at hospital conventions. The audit offers a superb opportunity to throw bouquets at the hospital group, from a conspicuous and newsworthy eminence.

• • •

Education of trustees in their duties and responsibilities is recognized today as of great importance. The audit offers an excellent aid in this, and the examiner should never fail to meet with the trustees for a full and frank discussion of affairs in the hospital. The proper relations of the trustees to other groups of workers may well be emphasized. Described as prominent citizens who enjoy headaches, trustees are usually persons of importance who influence the attitudes and ideas of the whole community.

• • •

A newspaper advertisement, perhaps misspelled, has a warning for those who work in our hospitals: "Altercation sale: partners splitting up," is the way it read. Pungent letters appear in magazines and newspapers. They contain bitter charges on both sides of the theme, doctors *versus* hospitals. The ancient alternatives, to hang together or separately, still threaten us.

Another of today's developments makes it more urgent to resolve the difficulties among hospital groups and to present a united front. The new development is the collection and disbursing of huge sums of money for special diseases such as polio, cancer, heart affections and cerebral palsy. Those in charge of the funds are mostly laymen, selected because of their success in financial matters. They have expressed indignation because of the friction in hospital affairs that interferes with the ideal of the best service to the patient. Perhaps the enlightening pressure of this group, with the added danger of government control, will be the lubricant to end friction.

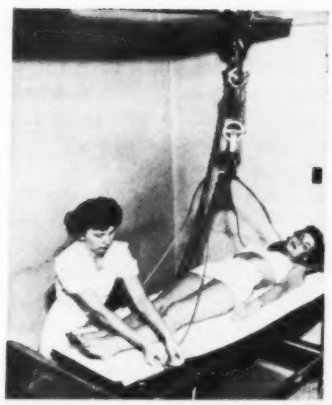
• • •

It is always interesting when the auditor is auditing at the same time that the surveyor for the Commission on Accreditation visits the hospital. There is always cordial cooperation for both have the same objectives. The fact that the medical staff and the trustees voluntarily spend money to buy criticism of their work is an index of their altruistic attitude. It should be another star in their crown of service.

• • •

Years of close association with welfare workers convinces me that they are much like onions. If you know how to handle onions, they can give a de-

Cleaned in a Few Minutes...READY FOR NEXT PATIENT



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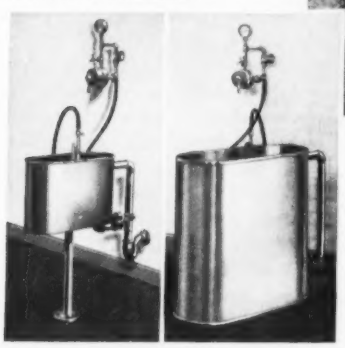

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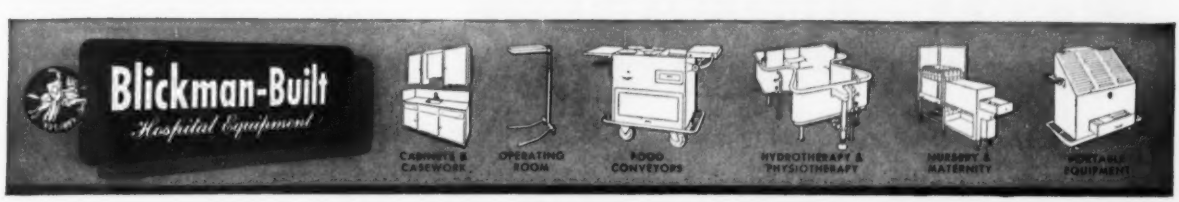

lightful tang to whatever is cooking. If you don't know what to do, you will get little but tears and unhappiness out of the effort.

• • •

Autopsies are expensive items for small hospitals in communities that do not have a full-time pathologist. Credit is not usually allowed for autopsies done in a mortuary by the coroner, unless the attending physician was present and there is a full report in the patient's record. One hospital that claimed an impressive autopsy percentage had only a single, brief report in its files. In some areas the coroner will not allow any person to be present at one of his autopsies except the coroner's physician. The reason for this is alleged to be the fear of damage suits by relatives of the victim. Somtimes the hospital council employs a pathologist to do the autopsies for several small hospitals in its district.

• • •

How few physicians realize that they should compensate for the privilege of working in the hospital by supporting its policies, also obeying its by-laws. If the staff would control its own affairs fairly and firmly, leaving other matters to the administration, there would be less turbulence in our hospitals.

• • •

"There's a very good reason why we have such a high cesarean rate. Our doctors are outstanding, and they get all the difficult cases in the city." That's a tired, shopworn claim, but a standard one. As I talk with people and listen to many more, I hear remarks like this: "I'm a general practitioner. I believe my patients will do better with a quick cesarean than with a long, difficult labor. I use the cesarean as routine."

"I always tie off the tubes after the second cesarean," says another. "Two's enough for any woman." But a nationally known specialist recently told me that he had two patients who soon would have cesarean operations for the seventh time. "I know of no reason for limiting the number," he said. Another told me with pride that he had guided 17 patients, who had previously had cesarean operations, through normal, nonsurgical deliveries. "I couldn't find any evidence of the contraction that was supposed to have required operation," he said, "and they had no trouble."

As I claim no special knowledge in this field, all I know is what they tell me. My attitude is that the best protection for the patient from exploitation, and of the doctor from calumny, is the requirement that every cesarean be discussed in medical staff meeting. There the attending physician and the consultant should be present to defend their decisions and procedures. The same principle applies to abortions and sterilizing operations.

• • •

"We have already adopted the Standard Nomenclature, several years ago," protested the chief of staff when this recommendation was made. But operations were being listed as "Explor. lap.," and diagnoses such as "cut knee" and "comp. fract. leg" were common. When I asked to see the book it was found after a lengthy search, and it proved to be out of date by several editions.

• • •

"This is Doctor A speaking."

"Hello, Doctor A. This is Doctor B. I have a patient in Room 202. She's in labor and I'm afraid she may have a hard time. I want to do a cesarean. Will you be the consultant?"

(*Continued on Page* 132)

STANDARD-ROYAL CAN HELP YOU

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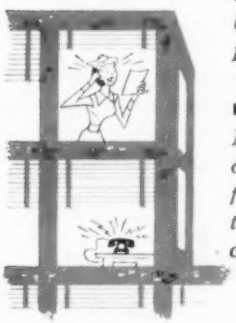
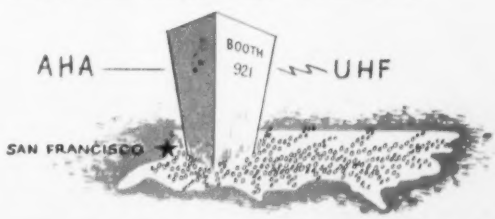


NIGHT SERVICE HOOK-UP . . . *Nurses answer any patient's call from any phone on any floor . . . eliminates duplication, expensive equipment and costly wiring.*

HOSPITALS cannot operate without Nurses any more than Armies without Soldiers . . . that's why, with today's acute shortage of Nurses, hospitals are rapidly installing ROYALMATIC Nurse Saver® Systems with their audible-visible, automatic answering and dual reset features. ROYALMATIC is the ultimate in nurses' call systems.

When you install ROYALMATIC you not only stretch your nursing personnel, but your operating dollars — often up to 63% when you reckon all forms of saving.

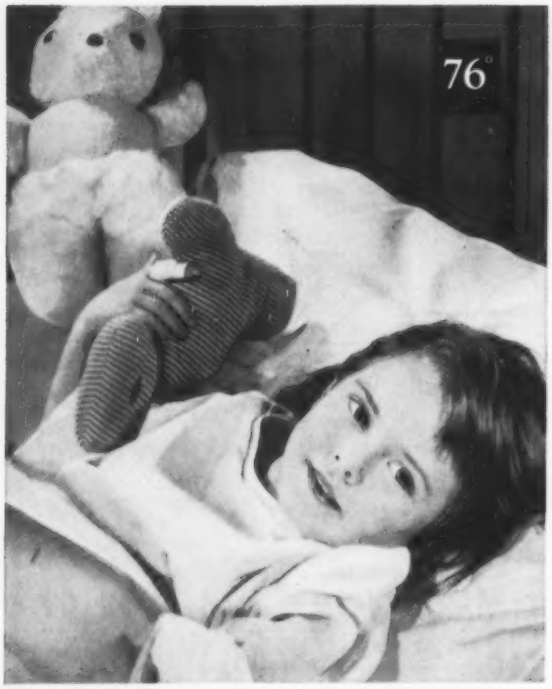
STANDARD-ROYAL Hospital Communication Systems give you better, faster patient service, increase your efficiency and cut your costs . . . in a word, give you brand new hospitals for old. It will pay you, as it has so many others, to get in touch with us and *Bring Your Hospital Up To Standard.*



ROYALCALL — *the sensational selective radio paging system for hospitals. Don't miss seeing, hearing and testing it at our Booth 921. Everybody is talking about it . . . Don't say we didn't tell you!*

Since 1884

THE STANDARD ELECTRIC TIME CO. STANDARD **69 LOGAN ST., SPRINGFIELD 2, MASS.**



IN ROOM 408, this active child is convalescing from a minor operation. Since this hospital has Individual Room Temperature Control, the temperature can be set at 76°, assuring proper comfort —even though she kicks off her blankets.

IN ROOM 303, this adult's physician feels 70° will prove beneficial to her recovery. That's why it's important to have a Honeywell Hospital Thermostat in each room—for then, room temperatures can be part of the prescription.

a thermostat in
every room is a

MARK OF A MODERN HOSPITAL

Today, in many modernly equipped hospitals, it is routine medical practice to give each patient the exact room temperature he needs to speed his convalescence. And this can be done *only* by having a thermostat in every room. No other method can compensate for the varying effects of wind, sun, open windows and variations of internal load in each room. That's why it's so important to consider Individual Room Temperature Control if you're planning to build or modernize a hospital.

Be sure you plan to install Honeywell Individual Room Temperature Control when your hospital is being built. This is the most economical time to have it done. And contrary to most beliefs, Individual Room Temperature Control is not expensive, for most installations will cost only between ½ and 1% of the total building expenditure.

For complete facts on Honeywell Controls for your hospital, call your local Honeywell office—there are 104 in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-9-55, 351 E. Ohio St., Chicago 11, Ill.

First thermostat specially designed for hospitals!

You get *all* these features only on a Honeywell Hospital Thermostat:

"***Nite-Glowing dials***" permit inspection without disturbing patients.

Magnified Numerals make readings easy to see.

New Speed-Set Control Knob is camouflaged against tampering.

Air-operated; requires no electrical connections.

Lint-Seal insures trouble-free, dependable operation.

MINNEAPOLIS **Honeywell**

First in Controls

THAT'S WHY

pure white

Fort Howard Paper Towels

OFFER YOU GREATER TOWEL ECONOMY!

The Fort Howard method of treating pulp fibers produces pure-white paper towels that dry faster, feel better, give you greater towel economy!

Take Fort Howard's pure-white Handifold: Controlled Wet Strength keeps Handifold strong and firm when wet, without sacrificing softness or absorbency. Stabilized Absorbency means that Handifold retains its drying ability regardless of towel age. And, like all Fort Howard Paper Towels Handifold has sufficient body for maximum absorbency.

Each of the eighteen grades and folds of Fort Howard Paper Towels has these three requirements of a good paper towel. In addition, all Fort Howard Towels are Acid Free . . . feel good, are easy on your hands. Call Your Fort Howard Distributor Salesman today!

For 34 Years Manufacturers of
Quality Towels, Toilet Tissue and Paper Napkins

FORT HOWARD PAPER COMPANY
GREEN BAY, WISCONSIN

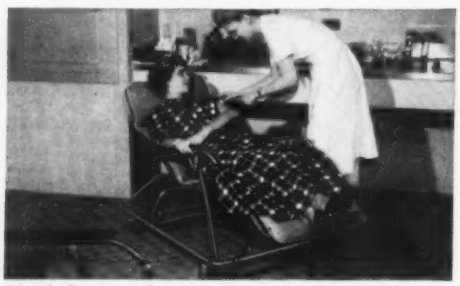
HOSPITAL COMFORT

by BARCALO

THE ONE AND ONLY BARCALOAFER

Here's the newest idea in hospital comfort! The one and only BarcaLoafer gives satisfying, scientific relaxation in any position the body desires, from upright sitting to full reclining. The BarcaLoafer is a *practical* chair. It has dozens of uses . . . as an adjunct in arthritic and similar cases . . . as a wheelchair . . . as a hospital room chair for visitors. Sold through selected hospital supply dealers.

- **Strong . . .** gives years and years of hard use!
- **Practical . . .** the chair with dozens of hospital uses!
- **Comfortable . . .** gives Barcalo's exclusive "Floating Comfort"!



Blood donor and treatment rooms are made more comfortable and inviting with BarcaLoafers. Cushions are covered with water repellent plastic fabrics in a variety of popular colors.

Undercarriage Attachment fits and locks easily to the base of the chair frame. Rear swivel wheels and handy foot brake. Tubular steel in matching enamel finish.

Simple undercarriage attachment converts the BarcaLoafer into a handy wheelchair. The BarcaLoafer has a strong tubular steel frame with durable baked-on enamel finishes.

THE FAMOUS BARCALOUNGER

The standard for reclining chairs. Ideal for examination rooms (electroencephlograph, electrocardiograph, etc), lounge rooms (staff and patients), overnight visitors. Smooth, silent casters.

Distinctive new Ebenaire. *Highly styled, durable, comfortable. Complete line of chairs, settees and tables. Very moderate cost — for solariums, lunch rooms, lounge rooms.*

Barcalo Mattresses and Box Springs. *"Bracer" top quality innerspring construction — comfortable and long-lasting. "Foamex" — comfortable, allergy-free, cool, durable — never needs turning.*

For Full Information *on all these famous Barcalo products, write to CONTRACT DIVISION, Barcalo Manufacturing Co., 225 Louisiana Street, Buffalo 4, New York.*

BARCALO OF BUFFALO

What's her Name?

Mary Jones, of course....

see the Ident-A-Band® on her wrist.

Yes, you know this is Mary Jones for sure, because she has the positive protection of the Ident-A-Band "on-patient" identification system all during her stay with you.

With an Ident-A-Band on her wrist there is never a question of identity, no matter where she is, what she is doing, how long she is with you. Just a glance tells the nurse and doctor her name, chart number, doctor's name and any other information you might require.

Her name with the other information on her wrist helps to make sure Mary Jones always gets her prescribed medication, her required treatment – nothing more. Important as well is the amount of time, effort and trouble the Ident-A-Band system can save your nurses.

The soft, plastic Ident-A-Band is securely yet comfortably sealed around the child's wrist. All necessary information about her is contained on the insert card which is sealed *inside* the band. Bands are easy to apply, not affected by oil or water, and are non-allergenic.

The Ident-A-Band's tough duPont Mylar lining makes it nearly impossible for the child to tear the band off. And there can be no "trading" of bands either – once sealed, the Ident-A-Band is so designed that it can never, ever be used again.

Very economical for the hospital too – costs only about 9¢ to 10¢ per child identified (depending on quantity). May we send you samples and complete information?

NAME _____

HOSPITAL _____

CITY _____

Please send me by return mail a sample HOLLISTER IDENT-A-BAND with detailed information at no cost or obligation.

Franklin C. Hollister Company GOODWILL BUILDERS FOR HOSPITALS

843 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

"Its so easy to get a perfect footprint everytime-with no mess, no stain."

the New HOLLISTER® Clean-Action *FootPrinter*

Announcing the sensational Hollister FootPrinter — an entirely new idea, a completely new method for taking footprints and fingerprints. Yes, you can now take clean, readable baby footprints without mess, stain or clean-up.

Fast, simple, easy to use — works like magic. Place baby's foot against FootPrinter plate, then take the print. That's all there is to it; baby's feet and nurse's hands are clean and you have a perfect print — everytime.

No ink, no special fluid, no special-treated paper needed. Ideal for use with Hollister *Inscribed* Birth Certificates.

Long life, low cost. Each FootPrinter plate takes 100 to 200 prints. Replacement plates easily snap in. New Nylon plastic case specially designed to fit nurse's hand, weighs less than 6 ounces.

Complete FootPrinter —
$9.50. Lots of 3, $9.00 each.

Replacement Plates —
$3.50. Lots of 3, Each $3.25.
Lots of 6, Each $3.00.
Lots of 12, Each $2.87½.

Special introductory offer below saves you $1.75.

Franklin C. Hollister Company

GOODWILL BUILDERS FOR HOSPITALS

Special Introductory Offer One New Hollister FootPrinter, complete and 3 Replacement Plates.
A $19.25 value only $17.50.

_____
QUANTITY WANTED

☐ Please send more information

843 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

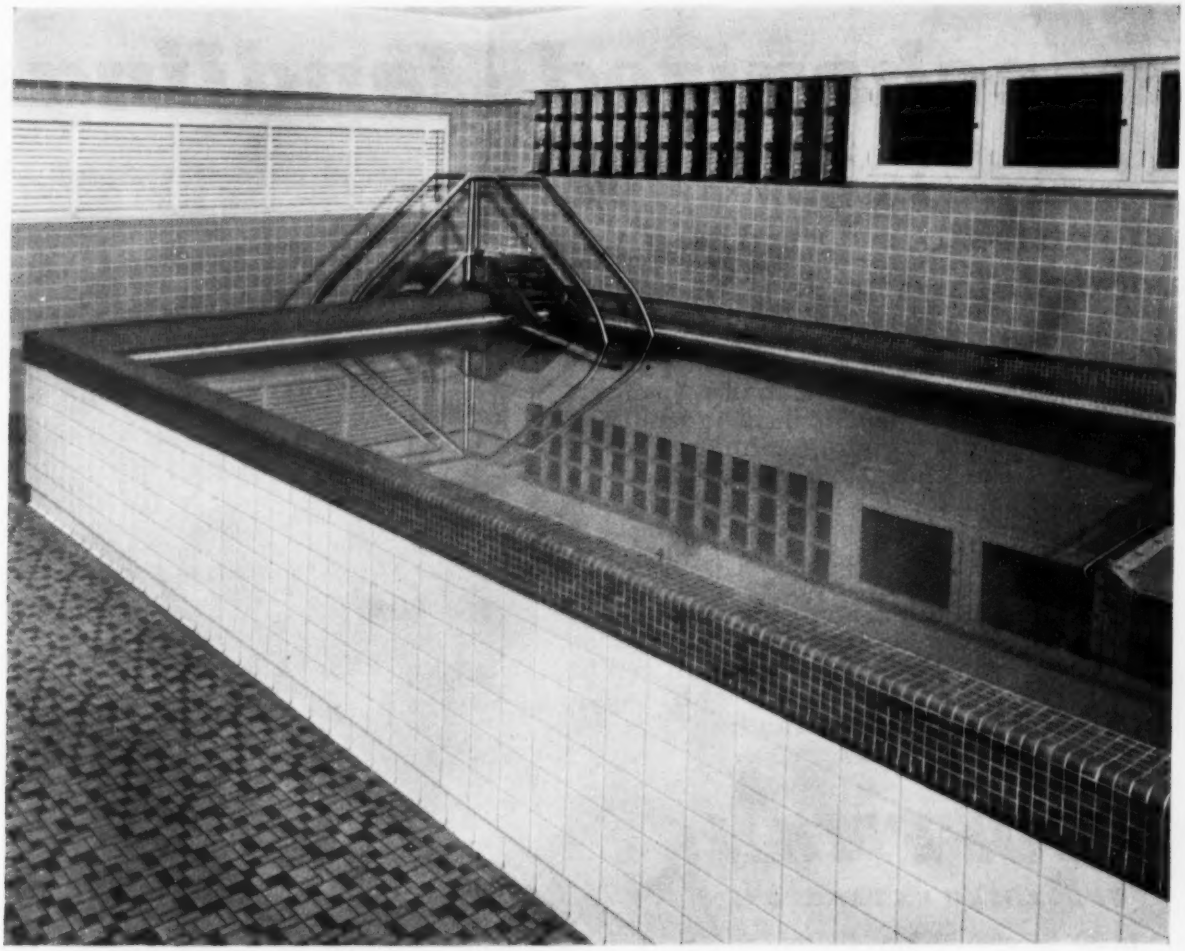
NAME _____

HOSPITAL _____

ADDRESS _____

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—30th Edition



Therapeutic Pool, Children's Country Home, Westfield, N.J.

TILE—when outstanding service is a must

This therapeutic pool must be in constant use, day in and day out. There's no time on the schedule for maintenance or repair.

That's why American-Olean Tile was chosen for the walls and floors, as well as for the pool itself. No other product could give such flawless service in this constantly high level of heat and humidity. Maintenance costs are zero. Cleaning couldn't be less—or easier.

Even when wet, tile provides a safe comfortable footing, and 50 years from now its cheerful colors will still be as fresh as new.

American-Olean Tile Co.

Executive Offices: 953 Kenilworth Ave., Lansdale, Pennsylvania
Factories: Lansdale, Pennsylvania and Olean, New York
Member, Tile Council of America

TILE SPECIFICATIONS FOR THIS ATTRACTIVE POOL:

Color Plate No. 329. Walls: 14 Spring Green. Cap and Base: 15 Sylvan Green. Floor: Random Pattern; Light and Dark Olive Textone. Outside Pool Wall: 97 Gardenia. Inside Pool Floor and Wall: 1⅛" White. Curb: ¾" Sage Shadowflash.

FREE COPY OF BOOKLET 300 shows you actual tile installations in washrooms, dispensaries, locker rooms, kitchens, and cafeterias, in full color, with complete tile specifications. Send for your copy today.

AMERICAN-OLEAN TILE COMPANY
953 Kenilworth Ave., Lansdale, Pa.

Gentlemen:

Please send me a copy of your new Booklet 300.

Name .....

Title .....

Institution .....

Street .....

City ..... Zone ..... State .....

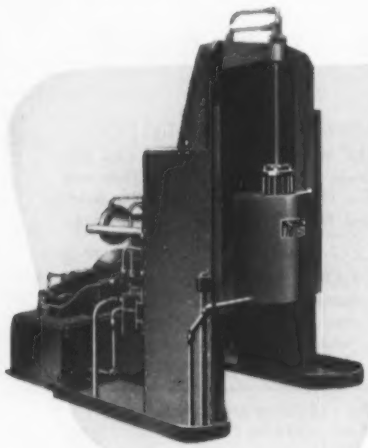
Mechanized Handling

saves you Manpower, Money, Minutes on Extraction of loads totalling in the tons.

More and more—laundry operators are finding it's "penny wise, pound foolish" to handle daily tonnage manually at extractors. Modern mechanical equipment speeds production and cuts cost by processing loads on a bulk basis. Avoids delays and bottlenecks—avoids high, non-productive labor charges. Now investigate how you can increase profits on every pound of work with Hoffman "mechanized handling" Extractors.

HOFFMAN
UNLOADING EXTRACTORS
in 50, 54 and 60-Inch Diameters

or...



the fast-cycle
HYDRAULIC EXTRACTOR
for 2,500 Pounds Per Hour

With unloading extractor, above, two basket halves of wet work are lifted by electric hoist—deposited directly into extractor. Then, extracted load is raised, rolled via overhead monorail, and dumped for tumbling or flatwork finishing.

Hydraulic Extractor provides 5-minute cycle for loading, extracting and unloading. 200-pounds per run. Quiet—vibration free—simple, single-lever control.

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

WHERE LIVES DEPEND ON INSTANT, UNFAILING SUCTION...

— thoroughly dependable equipment is a "must". Why not be *positive* that the suction units you specify are up to the highest standards — and which will always be instantly ready to give you the exact degree of suction you need — day after day, year after year?

NO. 930 — listed by Underwriters' Laboratories, Inc. and approved by CSA for use in hazardous locations, Class 1, Group C.

GOMCO®

SUCTION UNITS

— like the attractive No. 930 shown here, have earned the above reputation in leading hospitals and clinics for almost a quarter-century. Why not have your supplier demonstrate this dependable performance for you?

GOMCO Offers You . . .

- Explosion-proof construction.
- Aerovent automatic overflow protection.
- A complete line of suction and suction-ether units to fit your need and budget.

GOMCO SURGICAL MANUFACTURING CORP.
824-H E. Ferry Street Buffalo 11, N. Y.

New! for administering blood under pressure . . .
maximum **safety/efficiency**

the **R31** PLEXITRON expendable **Blood Pump**

Easy to use, efficient, and economical, the **R31 Blood Pump** offers maximum safety to the patient because of its unique design. Float-type valves at either end of the flexible plastic housing insure against air being forced into the vein. Rate of administration is controlled by the pumping action. Set may be introduced before or during administration and does not interfere with normal gravity flow. Sterile, designed for one-time use.

Partially shown at right is the R18 set designed for routine or pressure administration of blood, plasma, or serum. There is a PLEXITRON Expendable Set for every parenteral requirement.

products of

BAXTER LABORATORIES, INC.

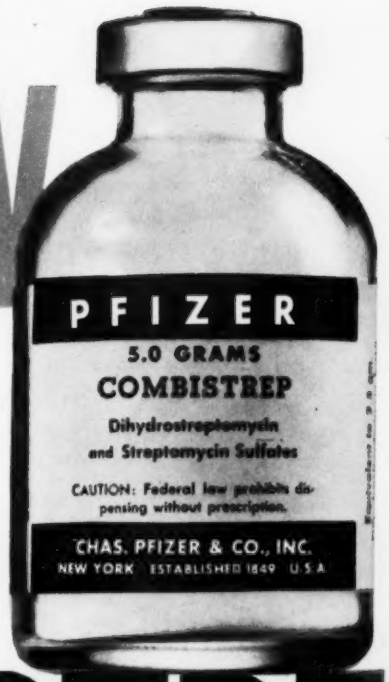
Morton Grove, Illinois • Cleveland, Mississippi

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

GENERAL OFFICES • EVANSTON, ILLINOIS

NEW



Streptomycin therapy ... with less neurotoxicity

COMBISTREP*

STREPTOMYCIN AND DIHYDROSTREPTOMYCIN COMBINATION

½ streptomycin - for less vestibular disturbance

½ dihydrostreptomycin -- for less auditory disturbance

Recent clinical trials with this combination, given over prolonged treatment periods, showed a significant reduction in both auditory and vestibular toxicity as compared to equivalent dosage of each antibiotic used alone.[1]

In two convenient sizes—

Dry powder for preparation of solutions for intramuscular injection. In silicone-treated, "drain-clear" vials:

1 Gm. 5 Gm.

(Stable for 48 months at room temperature)

1. Heck, W. E.: Reduced Ototoxicity by Combined Streptomycin-Dihydrostreptomycin Treatment of Tuberculosis, Scientific Exhibit 317; 102nd Annual Meeting A. M. A., New York, June 1-5, 1953.

Pfizer PFIZER LABORATORIES
Brooklyn 6, N. Y.
Division, Chas. Pfizer & Co., Inc.

Terramycin* Combiotic* Magnamycin*
Viocin* Streptohydrazid* Combistrep* (NEW)
Penicillin Streptomycin
Dihydrostreptomycin Polymyxin Bacitracin

*TRADEMARK

Does a **big job**

in just a **little space**

The American Juniorette Laundry

With this **professional** laundry equipment,

one operator

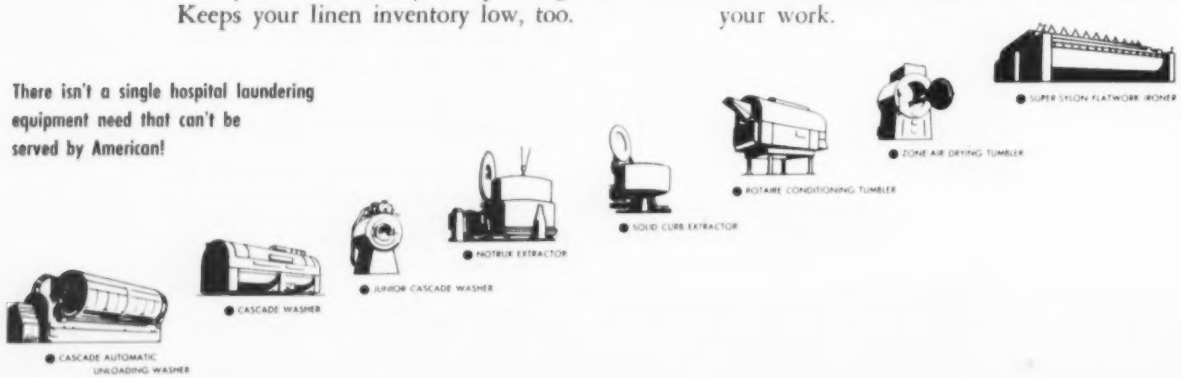
can keep you in clean linens every day!

For hospitals with light-to-moderate laundry loads, this American Juniorette Laundry does the job with big-laundry efficiency.

One of your present employees . . . in a few hours a day . . . can wash and iron all your linens . . . in a space as small as 12 x 14 feet. And the American Juniorette produces fast, low-cost, professional-quality work. It ends the annoyance and delays of make-shift equipment. It gives you complete control over your linens and your operating costs. Keeps your linen inventory low, too.

From the day you install a Juniorette, you profit from the advantages of American-engineered, American-built Laundry Equipment. Use the handy coupon to call in your American Laundry Machinery Representative for complete information on the American Juniorette Laundry, fitted to your specific requirements. His analysis of your work load can help you determine whether a complete Juniorette is needed or if a selection of one or more machines will do your work.

There isn't a single hospital laundering equipment need that can't be served by American!



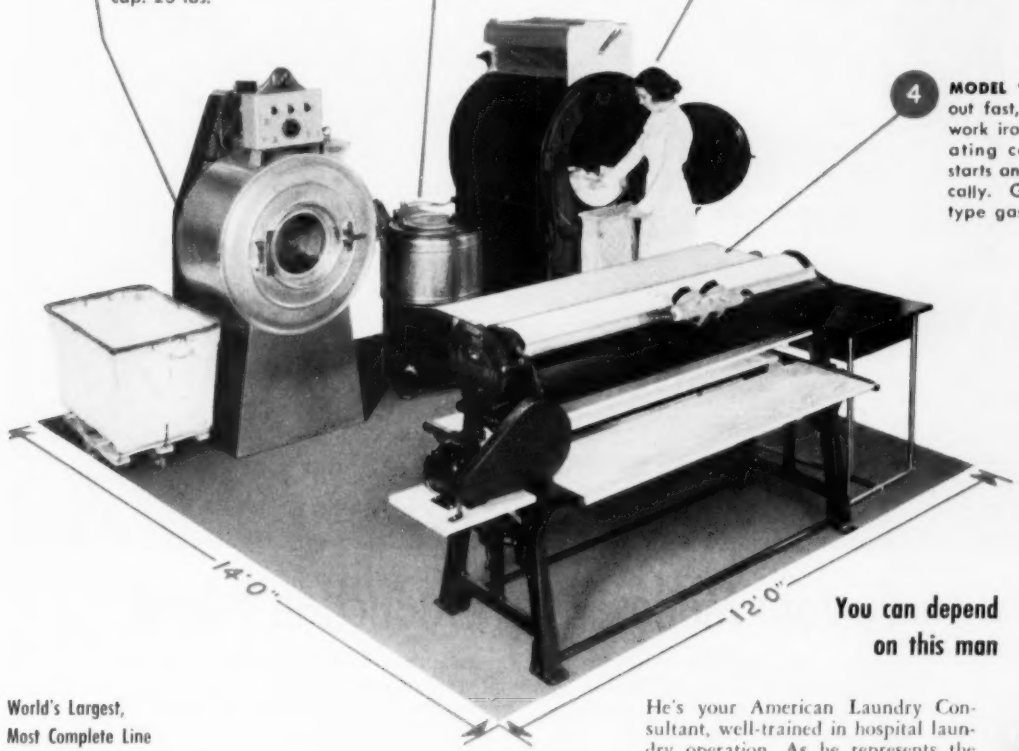
The **American** **Juniorette gives you this balanced combination of professional laundry equipment.**

1. **JUNIOR CASCADE WASHER with RINSOMATIC CONTROL** washes hygienically clean, with minimum water and supplies. Control automatically times the washing cycle and rinses automatically. Signals operator by light and buzzer. Saves time and steps. Dry wt. cap. 25 lbs.

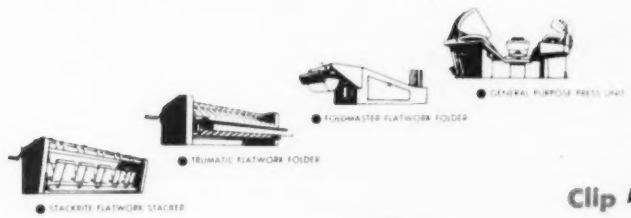
2. **MOTEX EXTRACTOR** quickly removes water from washed work for faster drying or ironing. Thorough, gentle extracting. Can be furnished with timer and automatic brake.

3. **AIRCRAFT TUMBLER** completely dries laundered work or pre-dries for faster ironing. Quick, economical drying of bath towels, mats and similar work. Gas heated for installation anywhere.

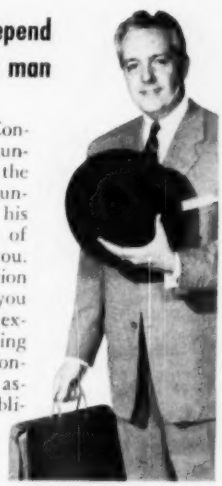
4. **MODEL "S" IRONER** turns out fast, fine quality flatwork ironing at low operating cost. Ironing roll starts and stops automatically. Gas heated, any type gas.



World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment



You can depend on this man



He's your American Laundry Consultant, well-trained in hospital laundry operation. As he represents the World's most *complete line* of Laundry Equipment, you can rely on his unbiased advice in your selection of equipment that's *just right* for you. He can help solve your production problems because he provides you with American's many years of experience in planning and equipping hospital laundry departments. Contact American for his specialized assistance at any time . . . without obligation, of course.

Clip AND MAIL COUPON NOW!

The American Laundry Machinery Company ALM-29A
Cincinnati 12, Ohio

☐ Send literature on American Juniorette Laundry.
☐ Please have American Laundry Consultant call.

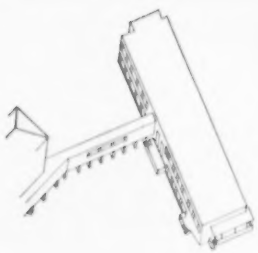
NAME_____

CARE OF_____

ADDRESS_____

CITY & STATE_____

The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO



Phoenixville Hospital, Phoenixville, Pa. Architect: Vincent C. Kling, Philadelphia, Pa. Builder: Nason & Cullen, Philadelphia, Pa. Windows: Special Lupton Architectural Steel Projected.

Custom Made, Mass Production Priced

Lupton Metal Windows for the new Phoenixville Hospital were custom designed to the architects specifications from stock members. Result . . . windows that "fit" the building . . . at considerable savings.

Window bays incorporate alternating fixed and ventilating units. Two open-out ventilators in the operating units provide ample natural ventilation and at the same time shield the openings from rain. Double weathering contact around the entire ventilator perimeter assures maximum protection from the elements when the windows are closed. Ventilator action is balanced for finger-touch control. Deep ventilator members and welded construction offer long service life with low maintenance costs.

Look for the Lupton name in your specifications. When you find it, you know you'll have window satisfaction for years to come. Long range value has been a Lupton Metal Window feature for over 40 years; through good design, quality materials and precision workmanship. Check with your architect, or call the local Lupton Representative (listed in the Telephone Yellow Section), or write direct for complete Lupton Metal Window information . . . it's yours for the asking.

MICHAEL FLYNN MANUFACTURING COMPANY
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member of the Steel Window Institute and Aluminum Window Manufacturers' Association

LUPTON
METAL WINDOWS

That means waxes containing Du Pont "LUDOX"

In growing numbers, hospitals and other institutions are turning to new anti-slip waxes containing Du Pont "Ludox" colloidal silica. Invisibly tiny particles of "Ludox" provide new walking safety.

Waxes properly formulated with "Ludox" have extra film hardness. They are fully equal to the best of floor waxes in gloss, water resistance, leveling, and other desirable properties. With all these advantages, you can see why waxes containing "Ludox" are specified by more and more safety and maintenance engineers.

If you are not already using anti-slip waxes containing "Ludox," ask your supplier about them. Or, if he cannot supply you with a wax fortified with "Ludox," consult E. I. du Pont de Nemours & Co. (Inc.), Grasselli Chemicals Dept., 4147-H Du Pont Bldg., Wilmington 98, Del.

How "LUDOX" gives slip resistance

As the foot presses on the waxed floor, submicroscopic particles of "Ludox" (so small that there are more than 300 trillion under the heel alone) press into larger, softer wax particles. This provides a unique snubbing action . . . helps keep the foot from slipping.

DU PONT
REG. U. S. PAT. OFF.

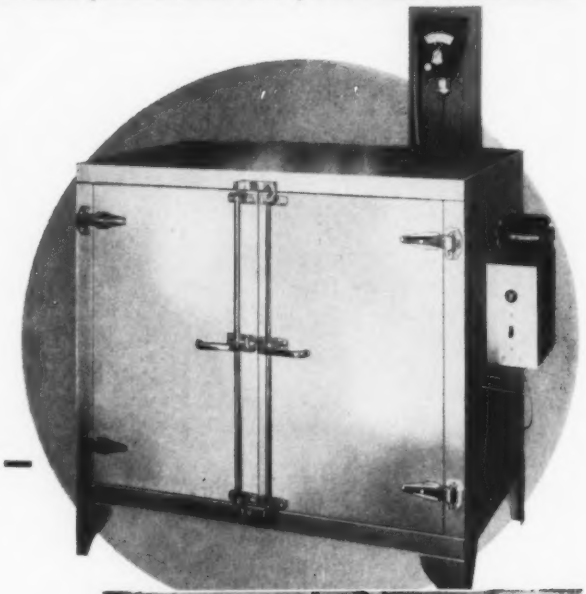
LUDOX
REG. U. S. PAT. OFF.
Colloidal Silica

BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

No hot or cool spots possible

The *Castle* No. 3
DRY HEAT STERILIZER

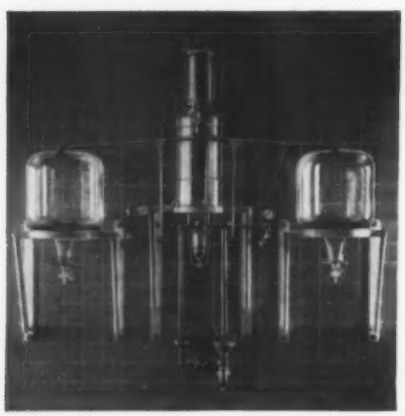
Incorporates a mechanical convection type heating and circulating system that insures a constancy of temperature — even in the remote corners of the chamber — that will not exceed ± 4°C. tolerance. Unexcelled for certain loads of anhydrous objects and substances, or articles not suitable for autoclave sterilization.



COMPARISON WILL PROVE THAT—

1. The velocity of air flow is approximately 100 times that of gravity convection thus assuring greater temperature uniformity.
2. Complete recirculation of heated air is accomplished with uniform diffusion and marked heating economy . . . no venting is required.
3. Heavy duty heating element, centrifugal turbo-blower and Partlow regulator permit adjustability of temperature at any point within the range of 38°C. to 260°C.

NOTE: Rock wool insulated double-wall construction of stainless steel throughout, including double doors which are also equipped with asbestos gasket seals and extra heavy hinges. Inside dimensions: 30" high, 36" wide, 20" deep. UNPRECEDENTED DURABILITY.



The *Castle* REFLUX STILL

Unexcelled as a reliable source of pyrogen-free distilled water. Will produce a distillate having less than 0.90 parts total solids per million parts water, at rate of 10 gallons per hour.

NEW RECORDING CONDUCTIVITY METER will reveal any deviation from the established standard of purity throughout the 24-hour day.

Typical Analysis of Water Distilled by Reflux Still at a rate of 10 gallons per hour

Odor	none
Color	none
Sediment	none
pH value at 20° C.	5.9
Heavy Metal (USP test)	negative
Oxidizable Substances (USP test)	negative
	parts per million
Total Solids	**0.85**
Volatile Solids	0.85
Inorganic Solids	0.00
Nitrogen	
Free Ammonia	0.034
Albuminoid	0.008
Nitrites	0.000
Nitrates	0.000
Chlorine	0.000

WRITE TODAY
for complete literature and specifications

Castle LIGHTS AND STERILIZERS

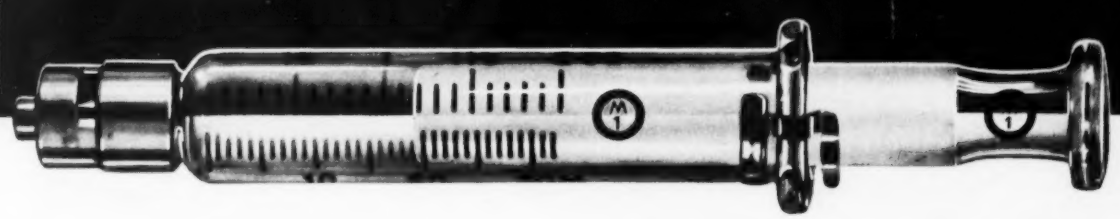
WILMOT CASTLE COMPANY
1175 University Ave. • Rochester 7, N. Y.

you can cut syringe costs

with

NEW B-D MULTIFIT® SYRINGES

"EVERY PLUNGER FITS EVERY BARREL"



Extensive hospital trials show that syringe costs can be lowered materially with new B-D MULTIFIT. The B-D MULTIFIT Syringe offers a unique combination of economies:

1 **Saves Time:** ease and speed of assembly cuts handling time—every plunger fits every barrel

2 **Saves Money:** in case of breakage, you lose *only* the broken part—the unbroken part remains in use

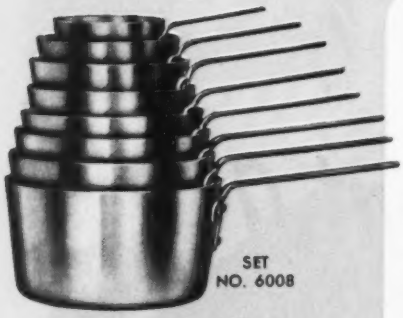
3 **Saves Material:** the clear glass barrel virtually eliminates friction, erosion and breakage.

BECTON, DICKINSON AND COMPANY • RUTHERFORD, N. J.

B-D

Dollar SPECIALS

Available through your dealer until OCTOBER 31, 1953 only



SET NO. 6008

Wear-Ever Aluminum 8-piece Sauce Pan Set

1½, 2¾, 3¾, 4½, 5½, 7, 8½ and 10 quarts —a size for every use. They nest for storage. Regular price—$36.20. (In Far West $40.20)

SPECIAL—$31.95

(In Far West—$35.50)

USE WEAR-EVER ALUMINUM

for

Superb Cooking—Durability
Ease in handling

Aluminum is one of the best conductors of heat known. Consequently, it spreads heat fast and evenly so that the whole utensil—not only the bottom—does the cooking. This results in uniform, superb food preparation and helps to avoid scorching and burning. All Wear-Ever utensils are made of an extra-hard alloy that gives added durability and long life, thereby cutting replacement costs. And because nature made aluminum light, these utensils are easy to handle.

NO. 4254

Wear-Ever Aluminum Heavy Duty 40-quart Stock Pot

Regular price—$35.50 (In Far West $39.45)

SPECIAL—$26.95

(In Far West—$29.95)

NO. 4310

Wear-Ever Aluminum 40-quart Stock Pot

Regular price—$17.65 (In Far West $19.65)

SPECIAL—$15.95

(In Far West—$17.75)

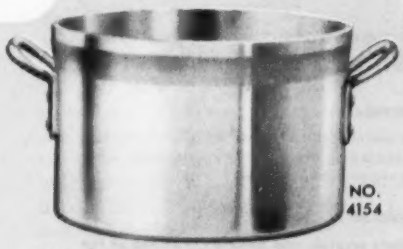
NO. 4305

Wear-Ever Aluminum 20-quart Stock Pot

Regular price—$11.00 (In Far West $12.20)

SPECIAL—$9.95

(In Far West—$11.05)



NO. 4154

Wear-Ever Aluminum Heavy Duty 26-quart Sauce Pot

Regular price—$29.95 (In Far West $33.20)

SPECIAL—$21.95

(In Far West—$24.40)

WEAR-EVER *Aluminum*

Symbol of quality for over 50 years

THE ALUMINUM COOKING UTENSIL COMPANY, INC., NEW KENSINGTON, PA.

WEAR-EVER *Golden Dollar*

UTENSIL COUPON

Use this certificate and save money!

Indicate quantity of each item desired in spaces provided. Then *give coupon to your dealer* with your order. This offer void in any state where prohibited or otherwise restricted.

_____ 8-piece Sauce Pan Sets @ $31.95*
_____ 26-qt. Heavy Duty Sauce Pots @ $21.95*
_____ 40-qt. Heavy Duty Stock Pots @ $26.95*
_____ 20-qt. Standard Rest. Weight Stock Pots @ $9.95*
_____ 40-qt. Standard Rest. Weight Stock Pots @ $15.95*

** Higher in Far West. See prices quoted under items in advertisement.*

NOT REDEEMABLE AFTER OCTOBER 31, 1953

The Aluminum Cooking Utensil Co., Inc., Dept. 709, New Kensington, Pa.

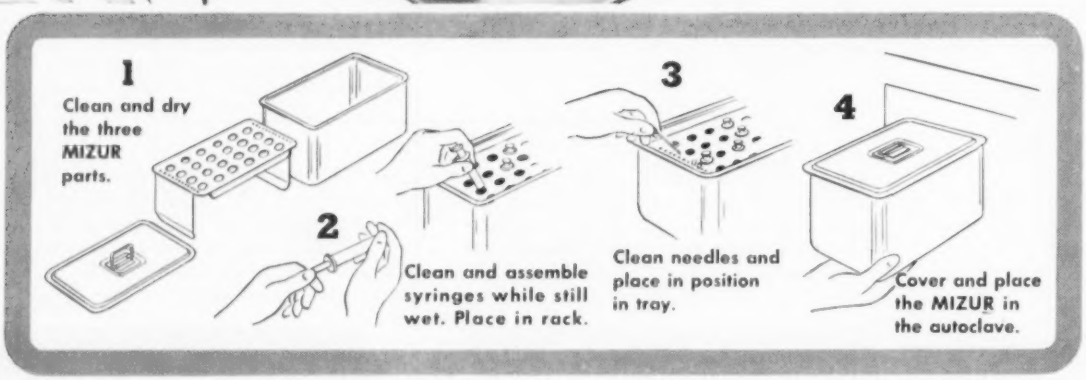
Cash Value—1/20 cent

The Mizur Technique Saves Important Minutes in Emergency Duty...Hours in Regular Duty!

In every phase of work where syringes are used or prepared, the MIZUR technique saves time. No more wasting time unwrapping syringes and attaching needles . . . No more waiting for syringes to arrive from Central Supply. The MIZUR cuts the preparation time from 2½ minutes to only 30 seconds per syringe. Saves up to 217½ nurse-hours a month for the average hospital using 1500 syringes weekly. With MIZUR, the syringes are always assembled and sterile—ready to save valuable time in emergencies —ready to save valuable hours in regular floor duties. You can't beat the MIZUR technique!

SAVES HOURS IN CENTRAL SUPPLY

CUTS BREAKAGE TO MINIMUM



Easy to Sterilize—Easy to Use—Easy to Clean!
MIZUR eliminates extra needle supply, extra handling, eliminates mixing of syringes and reduces breakage to a minimum. Made of sturdy stainless steel that won't tarnish. MIZUR will last a lifetime. Seamless construction insures *complete sterilization.* There are no cracks or crevices where bacteria can accumulate.

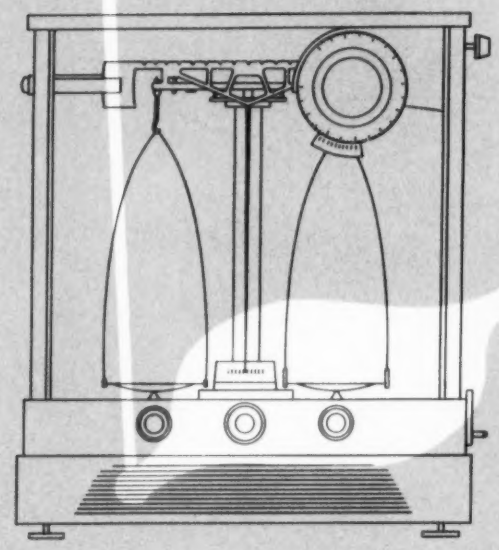
MIZUR

The most accepted hospital technique

Order from your dealer or write

Midwest Surgical Supply Co.—3877 No. 65th Ave., Omaha, Nebraska

for a balanced program of parenteral nutrition . . .



NOW!

5 NEW

Travert® 10%-Electrolyte

SOLUTIONS

. . . to supply increased carbohydrate

. . . to maintain electrolyte balance

5 NEW

Travert® 10%-Electrolyte solutions

all the advantages of Travert* plus replacement of electrolytes, and correction of acidosis and alkalosis

Travert-Electrolyte No. 1 1000 CC. CONTAINERS

(Na-80.0 mEq/liter, K-36.0 mEq, Ca-4.6 mEq, Cl-63.0 mEq, Lactate-60.0 mEq, Mg-2.8 mEq, Travert 10%)

. . . to supply electrolytes and correct mild acidosis

Travert-Electrolyte No. 2 500 CC. AND 1000 CC. CONTAINERS

(Na-57.0 mEq/liter, K-25.0 mEq, Cl-50.0 mEq, Lactate-25.0 mEq, Mg-6.0 mEq, HPO_4-12.5 mEq, Travert 10%)

. . . to furnish electrolytes when neither acidosis nor alkalosis is a problem

Travert-Electrolyte No. 3 1000 CC. CONTAINERS

(Na-63.0 mEq/liter, K-17.5 mEq, Cl-150. 5mEq, NH_4-70.0 mEq, Travert 10%)

. . . to supply electrolytes and correct mild alkalosis

Travert-Potassium 150 CC. AND 1000 CC. CONTAINERS

(K-40.0 mEq/liter, Cl-40.0 mEq, Travert 10%)

. . . to correct hypopotassemia where sodium is not necessary

Travert-Potassium in Half Normal Saline 1000 CC. CONTAINERS

(Na-77.0 mEq/liter, K-40.0 mEq, Cl-117.0 mEq, Travert 10%)

. . . to correct potassium and sodium deficiencies

Travert 10% Solutions provide:

twice as many calories as 5% Dextrose, in equal infusion time, with no increase in fluid volume; a greater protein-sparing action as compared to Dextrose; maintenance of hepatic function

products of

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DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

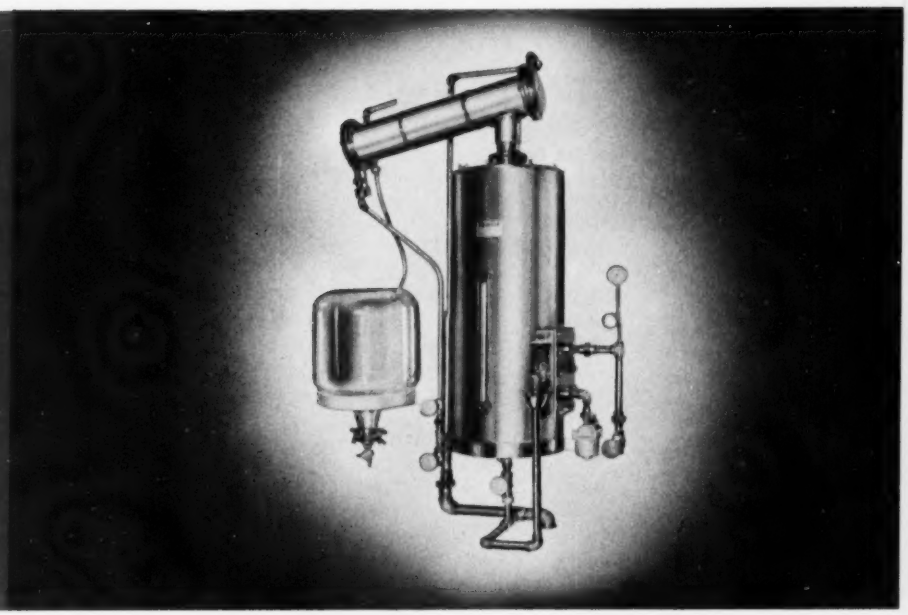
GENERAL OFFICES • EVANSTON, ILLINOIS

Announcing THE NEW

BARNSTEAD "15"

(15 GALLONS PER HOUR)

A New Water Still with 50% More Capacity to Meet Today's Increased Demands for Pure **DISTILLED WATER**



75 Years of Progress in Pure Water 1878 1953

- Supplies larger volume of pyrogen-free distilled water — faster. Designed to meet today's increased demands for distilled water in Central Supply Rooms and Pharmacies of larger hospitals.
- Compact wall-mounted unit. Mounts above counter in space only 48" wide including space for 12 gallon storage tank.
- Hospitals can save on equipment costs. The Barnstead "15" is priced at only a little more than a 10 gallon per hour still.
- With its 15 gallon per hour output the Barnstead "15" can often be used instead of 2 smaller stills — thus saving time, space and money for the busy hospital.

SPECIFICATIONS

Barnstead Model SMQ-15V — Steam Heated Water Still. Capacity 15 gallons per hour. For heating by steam at 40 to 60 pounds pressure. Equipped with demountable-type condenser, Spanish Prison Baffle, constant bleeder device, and easily cleanable evaporator. Supplied complete with all operating valves as illustrated. New type wall bracket. Suitable for hard or soft water. Price (with No. 0257 Wall Bracket) $822.00

Model MB-12 Distilled Water Storage Tank — Pyrex glass with pyrex stopcock. Complete with new-type wall mounting bracket. Price: $98.00 (Additional Pyrex tank) with 2-way valve assembly also available.

WRITE FOR INFORMATION TODAY!

Barnstead-Stills ESPECIALLY DESIGNED FOR HOSPITALS

. . . for the Purest, Pyrogen-free Water

The **BARNSTEAD "15"** gives you these important purity features for the positive removal of pyrogens:

BARNSTEAD VENTED CONDENSER

The Barnstead counter current, horizontal condenser effectively separates and expels gaseous impurities. One of the reasons why Barnstead distilled water is always pure — always pyrogen-free.

BARNSTEAD SPANISH PRISON BAFFLE

Spanish Prison Baffle within the evaporator is a Barnstead exclusive. This important feature scrubs the vapors rising from the evaporator to trap and strip out pyrogens. This feature is a must with modern hospitals, blood banks, and practically all pharmaceutical manufacturers.

BARNSTEAD CONSTANT LEVEL CONTROL

Constant level control has open hot well to expel gasses from the preheated feed water — thus eliminating most of the volatile impurities at the outset.

BARNSTEAD DEMOUNTABLE TYPE CONDENSER

The Barnstead demountable type condenser has easily removable ends so that cooling water tubes are readily accessible for cleaning.

BARNSTEAD SCIENTIFICALLY DESIGNED EVAPORATOR

Evaporator is wide and deep. Scientifically designed for low vapor velocity. Ample steam disengaging space above water level so that vapors rise slowly and lazily. 36" vapor rise for water to condenser entrance. Prevents entrainment at the outset.

BARNSTEAD STILL EASY TO CLEAN

Heating coil is mounted on removable plate on side of evaporator so that coil and evaporator interior are easily accessible for cleaning. With Barnstead design, daily cleaning is never required. Under average water conditions Barnstead Stills stay in service for months between cleanings.

BARNSTEAD CONSTANT BLEEDER DEVICE

Constant bleeder device continuously deconcentrates impurities within the evaporator. Foaming and priming is thus eliminated and scale formation greatly retarded.

Barnstead
STILL & STERILIZER CO.

27 Lanesville Terrace, Forest Hills, Boston 31, Mass.

A Special Still for Every Hospital • For Every Distilled, Pyrogen-free Water Requirement

75 Years of Progress in Pure Water
1878 1953

Barnstead

THE FIRST NAME IN PURE WATER

DEPENDABLE . . . UNIFORMLY SHARP . . . ENDURING CUTTING EDGES

ANY WAY YOU LOOK AT IT

. . . Performance-Proved

Any way you look at it . . . performance-proved B-P RIB-BACK SURGICAL BLADES contribute to the certainty of the surgeon's touch, as they provide him with dependable, uniformly sharp and enduring cutting edges.

B-P RIB-BACK SURGICAL BLADES are the result of meticulous care and fine craftsmanship in every detail of production.

The ECONOMY in the purchase of B-P RIB-BACK SURGICAL BLADES is proved by their performance!

Ask your dealer

BARD-PARKER COMPANY, INC.

Danbury • Connecticut

And Rib-Backs packaged in the new RACK-PACK provide further *economies* in time and labor for the O. R. Personnel. Blades from RACK-PACK to sterilizer in *a matter of seconds.*

It's Sharp

H-69

YOU'RE FAR AHEAD

when you serve these 4 great

...always fresh!...no waste!...

DANDY OYSTER CRACKERS

The sealed cellophane packet is your guarantee of freshness. Protected this way from moisture and humidity, the crackers can't go stale. Each packet contains just the right amount for one serving of flavorful, puffy oyster crackers—slightly salted on top and perfect for oysters, soups and cocktails.

RITZ CRACKERS

Here, in the convenient cellophane packet, is America's favorite cracker. Loss through bottom of the caddy breakage is a thing of the past . . . and the packets assure equal portions, two crackers each, per serving. Salty and crisp, Ritz packets are the perfect mate for entrees, soups, salads and cheeses.

SEND FOR FREE SAMPLES AND THIS FREE BOOKLET Packed with ideas on how to increase sales and cut food cost with DANDY OYSTER Crackers • RITZ Crackers • FOUNTAIN TREATS • PREMIUM Saltine Crackers and other NABISCO products.

National Biscuit Co., Dept. 23, 449 W. 14th St., New York 14, N. Y.
Kindly send free samples and new booklet "America's Home Favorites."

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WITH NABISCO...

individual food packets!

saves time!...top quality!...

FOUNTAIN TREATS

Add that extra touch to your hot and cold drinks, sodas and ice-cream by serving Fountain Treats in the cellophane packet. Serving time is cut and waste, through breakage and staleness, is eliminated. Handsomely displayed in each packet, the delicious chocolate and vanilla sweet cookies are fountain favorites.

PREMIUM SALTINE CRACKERS

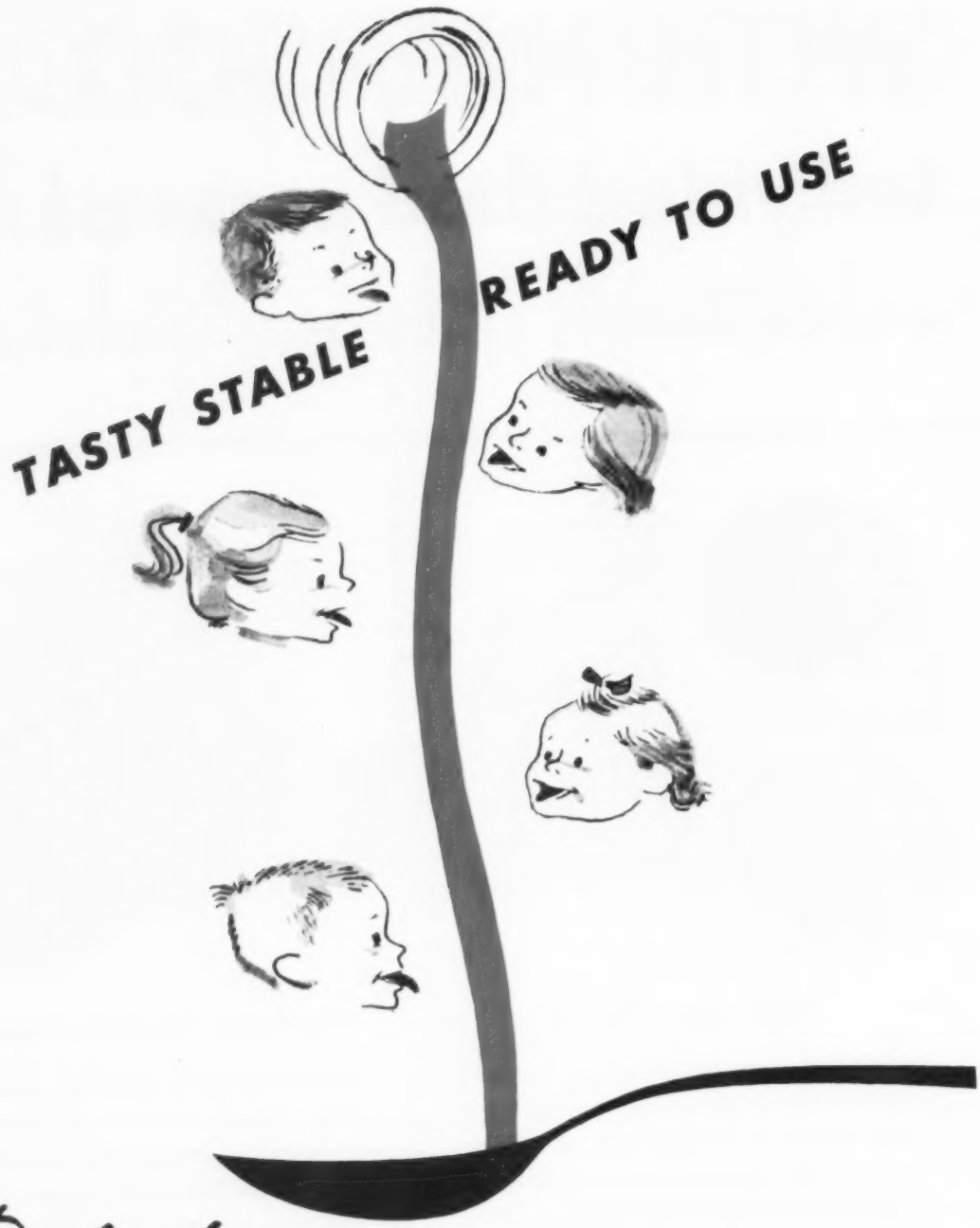
There's nothing quite like these flaky, salty Premium Saltine Crackers in the cellophane packets. The packet is your assurance that they'll taste oven fresh always—and you save money because there's no breakage, wastage either. Serve with soups, chowders, salads—and as a thrifty substitute for bread.

OTHER NABISCO FAVORITES

NABISCO SHREDDED WHEAT • FIG NEWTON CAKES
NAB PACKETS • LORNA DOONE SHORTBREAD
OREO CREME SANDWICH • NABISCO GRAHAM CRACKERS • NABISCO PRETZEL VARIETIES
TRISCUIT WAFERS

251 distributing branches assure prompt and frequent delivery

NATIONAL BISCUIT COMPANY



Pediatric

Erythrocin TRADE MARK **stearate**

(ERYTHROMYCIN STEARATE, ABBOTT)

Oral Suspension

1-220

ESPECIALLY RECOMMENDED

against staphylococcic, streptococcic, pneumococcic infections

ESPECIALLY ADVANTAGEOUS

in children sensitive to other antibiotics or when the causative organism is resistant to them

SUPERIOR

because it is less likely to alter the normal intestinal flora than other oral antibiotics, except penicillin

Offering a new advantage

in antibiotic therapy, *Pediatric* ERYTHROCIN Oral Suspension provides the effectiveness of ERYTHROCIN in a sweet, cinnamon-flavored form. There's no problem in administration—tests show that children really like this orange-colored preparation.

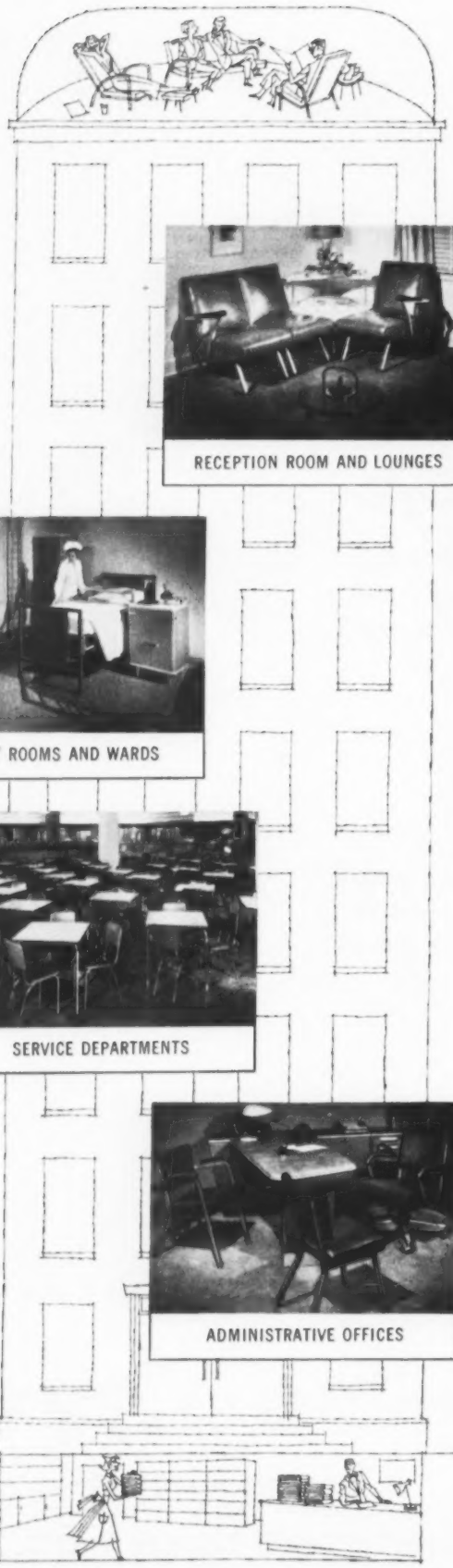
No mixing required. *Pediatric* ERYTHROCIN Suspension is ready for instant use. Tested for stability at extreme temperatures, the drug will remain potent for at least 18 months.

Like ERYTHROCIN tablets, *Pediatric* ERYTHROCIN Suspension is specific in action—*less likely to alter the normal intestinal flora than other oral antibiotics, except penicillin.* Gastrointestinal disturbances are less common, with no serious side effects reported.

Pediatric ERYTHROCIN Suspension is indicated in pharyngitis, scarlet fever, pneumonia, erysipelas, pyoderma, certain cases of osteomyelitis and other infectious conditions. *Especially indicated in staphylococcic infections*—because of the high incidence of staphylococcic resistance to penicillin and other antibiotics.

Recommended dosage is 2 to 3 mg./lb. (4.5 to 6.5 mg./Kg.) at four to six-hour intervals. Thus, one teaspoonful every four to six hours for a 50-pound child. Can be administered before, after or with meals. *Pediatric* ERYTHROCIN Stearate Oral Suspension, representing 100 mg. of ERYTHROCIN per 5-cc. teaspoonful, is supplied in 2-fluidounce, pour-lip bottles. Abbott

ALSO NEW: ERYTHROCIN OINTMENT, 1%, IN 1-OZ. TUBES



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PATIENT ROOMS AND WARDS

SERVICE DEPARTMENTS

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DORMITORY ROOMS

from top to bottom...

Royal offers the most complete range of fine metal furniture for every hospital department

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COME, *Clean with a* Clarke!

Clarke Floor Maintainers come in 11", 13", 15", 17", and 23" sizes. They scrub, wax, polish, steel wool, shampoo, disc sand, or grind. Accessory water tank available.

35th Anniversary

Clarke floor maintenance equipment will keep your floors spotlessly clean, like-new in appearance and sparkling bright day after day. Clarke takes the drudgery out of floor care by making equipment e-a-s-y to handle and whisper-quiet. Floor care can go on any hour of the day without disturbance. Clarke builds **rugged** machines to free you from irritating time-out for repairs. But — **above all** — Clarke machines **clean!** And they work fast — saving time and materials and drastically lowering your maintenance cost per square foot per year. What more could you ask of any maintainer? Buy a CLARKE! Mail the coupon for full details.

A great cleaning companion

the CLARKE WET-DRY VACUUM

Here's the ideal machine wherever water, dust and dirt must be picked up. Quick-draining dump valve eliminates heavy lifting . . . powerful suction . . . easy to handle . . . useful for any type floor, drapes, overhead fixtures, venetian blinds, any hard-to-reach places. Porcelain inside and out. WD-23 for large areas, WD-15 for smaller areas.

Make this minute valuable to you — mail the coupon!

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Clarke authorized sales representatives and service branches are only hours away from you in principal cities throughout the country.

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Send me full illustrated information on the following:

☐ Wet-Dry Vacuum Cleaners ☐ Floor Maintainers

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for clean . . . quick . . . efficient food service

this U. S. Naval Hospital

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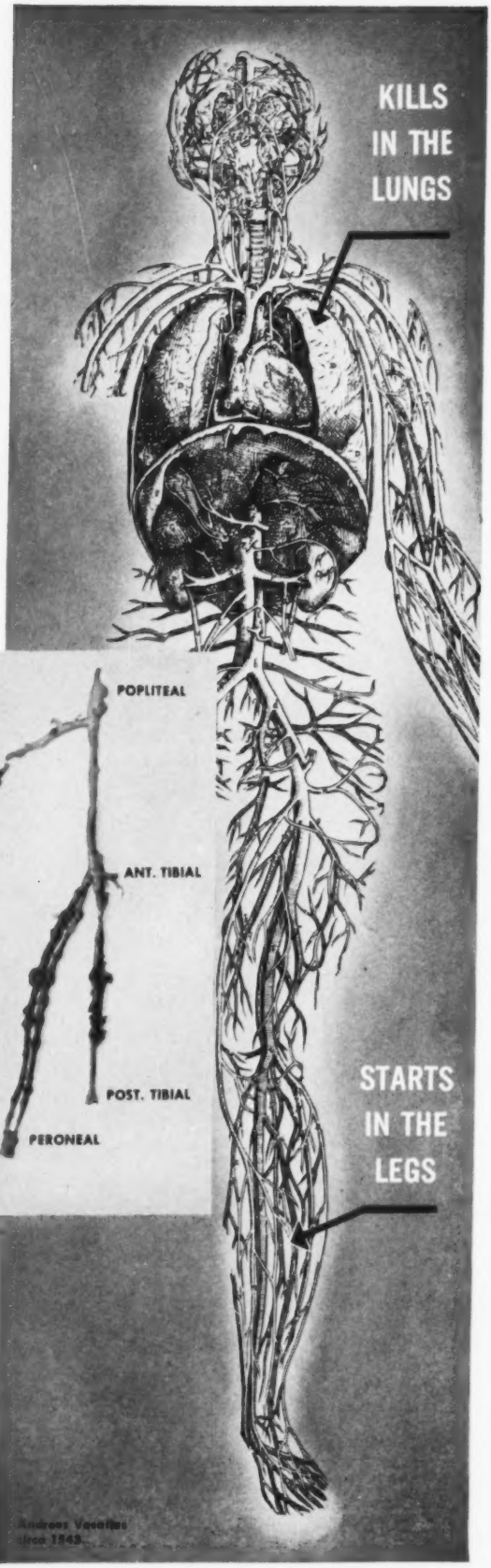
Commanding Officer: Capt. A. B. Chesser, Medical Corps, U.S.N.; *Executive Officer:* Capt. R. S. Simpson, Medical Corps, U.S.N.; *Commissary Officer:* Lt. O. R. Scheile, Medical Service Corps, U.S.N.; *Chief Dietician:* Lt. Eva Minkel, Navy Nurse Corps

Toasters, griddles and fryers in the service area.

T.E.D. Elastic Stocking Routine SAVES LIVES

Deaths from pulmonary embolism were halved among thousands of patients using new routine at Massachusetts Memorial Hospitals



In the majority of cases, pulmonary embolism results from circulatory stasis incident to bed rest.

Most fatal emboli originate in the deep calf veins of the leg—an area in which prophylaxis is easily accomplished by simple compression of the leg by use of a new type of inexpensive elastic stockings, T.E.D. Elastic Stockings, developed exclusively by Bauer & Black in cooperation with Massachusetts Memorial Hospitals. These stockings exert just enough pressure to speed blood flow through the deep leg veins and minimize clot propagation.

A new routine, established at Massachusetts Memorial Hospitals, calls for wearing T. E. D. Elastic Stockings by bed patients as *standard procedure* (except in cases of ischemic vascular disease of the legs in which use of the stockings is contraindicated).

Tests of the new routine on more than 5,000 patients showed only half as many deaths from pulmonary embolism among patients wearing T. E. D. Elastic Stockings as among a control group not wearing the stockings.

For an illustrated report on continuing embolism studies, write to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Illinois.

(Right)—Photo inset shows deep calf veins of pulmonary embolism victim. Note beaded appearance of veins which were filled with ante mortem clot. Note that parts of posterior tibial have greater diameter than the popliteal. Autopsy studies indicate that most fatal emboli originate from clots in the deep leg veins.

Specimen photograph courtesy of Joseph R. Stanton, M.D., Massachusetts Memorial Hospitals and Boston University School of Medicine.

T.E.D.®
ELASTIC STOCKINGS

BAUER & BLACK

Division of The Kendall Company
309 West Jackson Blvd., Chicago 6, Ill.

Hospitals with a clean look that lasts—

it's built-in with Facing Tile

"Cleanliness throughout—at the lowest possible cost."

That's one of the essentials of hospital planning which structural clay Facing Tile can help you to achieve.

Facing Tile's hard-glazed, impervious surface prevents accumulation of dirt or bacteria, washes down so easily that clean-up time and labor are cut to a minimum. And it cannot be harmed by powerful disinfectants.

Best of all, this clean look lasts the life of the building. The durability of Facing Tile has been proved by years of use in hospitals. Its cheerful, light-reflecting colors never fade. It stands up under heavy hospital activity. Your budget is never strained by costly refinishing.

The first cost of Facing Tile is less than you would think, too. It goes up fast, builds a load-bearing wall and a permanent finish in a single step.

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1520 18th Street, N. W., Washington 6, D. C. • 1949 Grand Central Terminal, New York 17, N. Y.

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Main Kitchen, Greenwich Hospital, Greenwich, Conn. Skidmore, Owings & Merrill, Architects

Serving Pantry, Beth El Hospital, New York, N. Y. Isadore Rosenfield, William I. Hohauser, Architects

LOOK FOR THIS SEAL

Used only by members of the Facing Tile Institute, it is your assurance of highest quality. In the interest of better Facing Tile construction these companies have contributed to the preparation of this advertisement.

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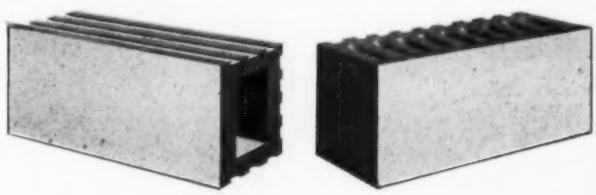
Charleston 24, West Virginia

GET YOUR FREE COPY OF THIS BOOK ON SELECTING INTERIOR COLORS

"The Scientific Approach to Color Specification" was developed by noted color authority, Faber Birren. It describes how Facing Tile has been "color-engineered," tells you how to choose the *right* colors for hospital interiors. Just address your request to any Institute Member or Dept. MH-9 of our Washington or New York offices.



—No other single building material gives you so much for so little— **IT'S FACING TILE**

NEW

Davis & Geck's Spiral Wound Surgical Gut on a cylindrical reel!

Saves time makes easier ties

Surgeons welcome a new convenience—D & G Spiral Wound Surgical Gut. It is wound on a cylindrical reel—comes *ready for immediate use* in ligation and suturing. Spiral winding preserves all the original strength. None is lost through kinks or bends.

Nurses, too, save time with Spiral Wound Gut. No more unwinding from an old style flat reel and rewinding onto a rubber tube, glass rod or spindle.

For surer hand ties

When the surgeon makes a series of hand ties, D & G Spiral Wound Surgical Gut USP unreels in his hand, free from kinks, with all its tensile strength preserved.

The gut should be gently pulled out straight immediately after removal from the tube.

D & G foresees the surgeon's needs

D & G Spiral Wound Gut is the latest Davis & Geck contribution to improved suturing. "Timed-absorption" surgical gut is another—this exclusive D & G method embodies accurately graded degrees of chromicizing. The suture resists digestion most strongly during the first postoperative days, when greatest strength is needed. It is absorbed more rapidly when tissues have regained their natural strength.

Hospitals!

You will find that Spiral Wound Gut saves time in the O.R. Economical, too. It preserves full strength of sutures —no waste.

Davis & Geck, Inc.

A UNIT OF AMERICAN Cyanamid COMPANY

57 Willoughby Street, Brooklyn 1, N.Y.

Small Hospital Questions

Administrators' Salaries

Question: Our board has determined that administrative salaries in our hospital (242 beds) should be established within the range of comparable salaries in comparable hospitals. They have asked that we gather some specific data for their consideration. Do you know the salary situation of a number of other hospitals of our size?—D.C.C., Ind.

ANSWER: The last MODERN HOSPITAL survey shows that in the Midwest the average administrative salary in hospitals of 201 beds and more was $15,200. These data were actually collected in the first part of 1952, and we suspect that in general there has been some increase since that time. As an example, a hospital in Illinois having 245 beds and 30 bassinets is now looking for a new administrator, and is offering, as a starting salary, $15,000 to $18,000, depending upon the man and his experience.

The more progressive, enlightened boards have for the past several years come to the conclusion that, if they are to get the type of able, thoroughly trained, experienced hospital administrators they must have to administer the complicated affairs of a hospital successfully, they have to pay executive salaries comparable to the executive salaries paid in industry and business of about the same responsibility, volume and size.

By and large, hospitals have discontinued the old system of offering living quarters and meals in addition to cash. Also, many administrators now enjoy a one month vacation and have an agreement that the hospital will pay expenses to state, regional and national hospital meetings. There are also a growing number of institutions that provide a pension retirement plan in addition to cash salaries.

Blood Donations

Question: What is the practice for obtaining blood donations in smaller hospitals and communities?—F.F.K., Ky.

ANSWER: It is essential to teach the people in any community that two pints of blood must be donated for every pint given to a patient. It is usually easy to explain this, although in a community where it hasn't been the practice, it takes a little time, patience and public education.

Most hospitals have found it is better to try hard to work on the basis of two donations for one transfusion of blood rather than to follow the suggestion of purchasing blood from the public at a stated price per 500 cc. and continuing with the ratio of one donation for one administration. In most parts of the country, the minimum price for 500 cc. of blood would be from $20 to $25.

Delegating Responsibility

Question: I am a member of the board of trustees of a hospital. A problem has arisen regarding the duties of the administrator as they affect those of the director of nurses. I am writing to ask if you have any information as to the authority of these two officers, where one begins and the other takes up. I imagine these duties vary according to the size of the hospital; ours has 200 beds.—H.H.M., Md.

ANSWER: It is a little difficult to answer the question completely. Certainly the administrator of the hospital is, or at least should be, completely responsible for the work of every department head, including the director of nursing service and nursing education. There is no difference at all in the organization of a hospital and that of any well run industry or business. The top executive, no matter by what name he is called, must expect to accept the responsibility for everything in the hospital. If he is a good executive, he will delegate responsibility and the authority that must go with it to all department heads.—E. W. J.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Alta, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Recognition of Donors

Question: Our hospital has embarked on a comprehensive refurnishing plan to replace the majority of our present patient-room furniture, which is initial equipment and now more than 20 years old.

All of our rooms were originally furnished by various individuals, groups and community organizations. What should be our approach to this situation? It seems that these original groups or individuals should be given an opportunity to renew their gifts. If the person or group declines such an offer, is it reasonable to assume that the original gift has outlived its purpose? Another slant to the problem is that other groups, not included in the original donor list, now wish to furnish a room as a memorial. This would necessitate removing the original plaque from the door to replace it with one noting the present donor. Also, if the original donor is deceased or the original donor organization is defunct or reorganized, should the heirs or present membership be approached? If the hospital refurnishes the room, it wouldn't seem entirely fair to retain the plaque noting the original donor. The hospital certainly doesn't wish to turn away those groups that wish to refurnish a room completely, and we appreciate the need for recognizing this donation in some concrete way, such as a plaque on the door.

Is there any way these original donors can be "honorably retired" to make way for new contributors and groups interested in the hospital without offending anyone or stirring up rancor? Perhaps a "master plaque" could be set up to which their names could be transferred. It might be mentioned that only the furnishings are concerned in this arrangement.—A.T., N.Y.

ANSWER: In general, it would appear to be entirely proper to approach the original donors or their heirs to see if they wish to make new gifts to refurnish rooms. When you finally get all the donors lined up to refurnish the rooms, you would certainly want to put some kind of plaque on either the door, or, preferably, the corridor will immediately adjacent to the door, honoring the people who gave the money. In many cases the people who gave the money will want to give it as a memorial to someone. In that event, the name of the person in whose memory the room has been refurnished should also be given.

To handle all the original donors who are not interested now in refurnishing the room, or when you can't locate them, you could have one plaque prepared simply giving a list of former donors of funds to furnish the original rooms. The former donor list might be placed somewhere in a main lobby or main corridor.

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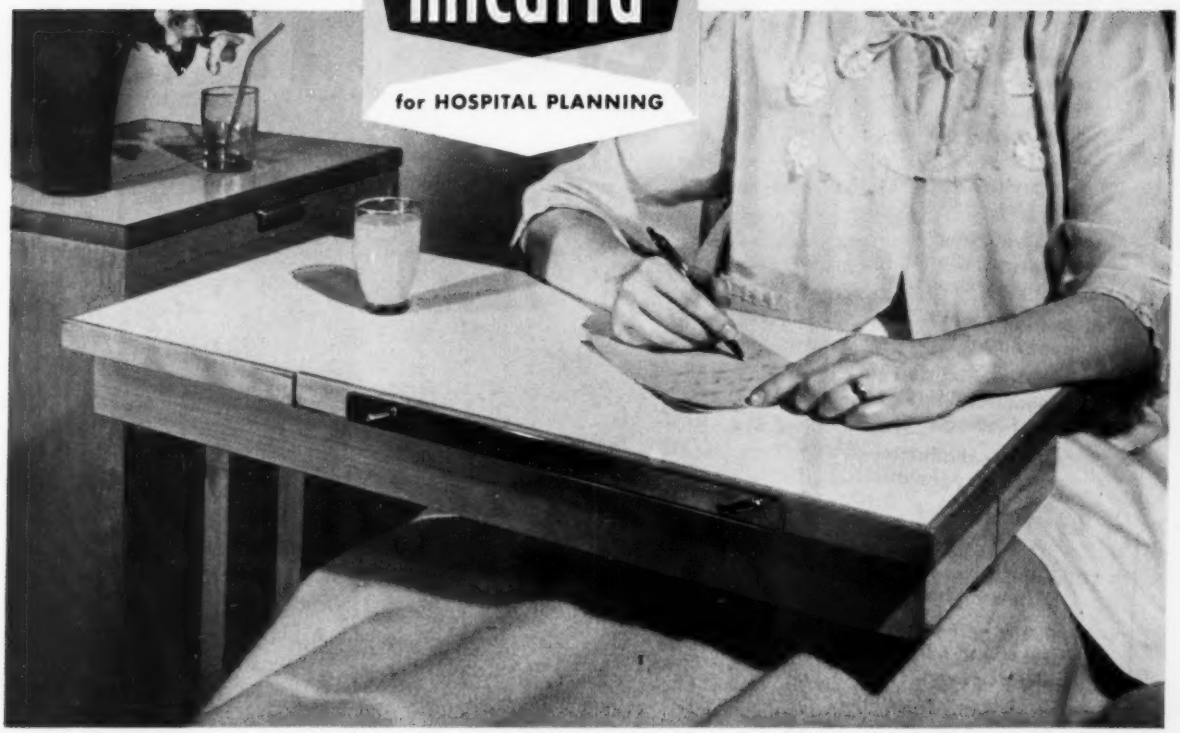

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HILL-BURTON OUTLOOK

While the Hill-Burton hospital construction program generally is respected as valuable and well administered, it suffers under one disadvantage that may prove fatal: It is one of the biggest grant-in-aid projects of the federal government and one over which Congress has direct and undisputed control.

Troubles encountered in getting even a modest appropriation out of Congress last session may be only a sample of what is in store for H-B during the next few years.

It is ironic that this program, whose directors generally have managed to steer away from politics and political philosophies, is running headlong into a philosophic cornerstone of the Eisenhower administration. Long before his election, Gen. Eisenhower voiced the philosophy that the federal government had to cut down on services that, in his opinion, are state and local responsibilities. In this the general was joined by the late Senator Taft and virtually all the other key Republicans in House and Senate.

It is true that Eisenhower himself and the Republican platform seemed to make an exception of hospitals, but the "exception," if there was one, appeared to have been pretty well forgotten on Capitol Hill last session when appropriations were under discussion.

At appropriations committee hearings, particularly in the House, the question "Why can't the states do this?" was constantly present. As a result, every major state grants program in the health fields suffered reductions, some so drastic as virtually to wipe out the operations.

Venereal disease control work this year has about half the money it had last, and this program's directors were warned by the House committee that pickings will be still slimmer next year, because "the point has been reached where the states and communities can take care of the problem with a minimum of assistance from the federal government."

For helping states and communities to detect and treat tuberculosis cases and to develop new technics, the federal government has $6 million this year, or 25 per cent less than last year. Here again the House warned that this program should be entirely a state responsibility.

Another example is control of communicable diseases other than venereal and tuberculosis. This money also is passed on to the states to help them do the work. But this year there will be only $5 million, or a reduction of between 40 and 50 per cent from last year's appropriation.

Considering what happened to these smaller grant-in-aid programs, the Hill-Burton appropriation came through miraculously well. The House, playing no favorites, made a 33 per cent cut from last year—to $50 million. By the time it was up for passage in the Senate, estimates had been prepared on just where the cuts would be made and just what hospital jobs would suffer. States due to suffer the most turned on the pressure. The Senate pulled up its figure to $75 million, a total that hadn't been even mentioned this year except in the discarded Truman budget.

Senate conferees fought doggedly and threatened to keep Congress in session for this one item if the House insisted on holding to its figure of $50 million. Eventually the compromise came—$65 million, the lowest figure in recent years but still not too bad, everything considered.

There is no possibility that the administration will let up on its demand that states take over more of the medical-social load. Already a commission is at work on a study of how responsibilities can be shifted. The Commission on Intergovernmental Relations, appointed by Congress and the President, is under instructions to report back with recommendations by next March 1. For one thing, it hopes to find taxation areas from which the federal government can retire in favor of the states, in return for which the states will have to assume the full cost of certain grant-in-aid programs.

A check of statistics suggests that at its present rate the Hill-Burton program is not correcting any hospital-bed deficiencies but that construction is hardly even keeping up with the population increase and hospital deterioration. One estimate is that in the six years the program has been operating, a dent of only 50,000 beds has been made in the 900,000 bed shortage. If the program is started down grade before states and communities can be induced to spend more of their own money, this 50,000 bed gain will be wiped out in a short time.

To keep within its budget for hospital planning services, Public Health Service has eliminated the Division of Medical Hospital Resources, formerly directed by Dr. John McGibony, who has resigned to become professor of hospital administration at the University of Pittsburgh.

About 50 employes of the division have been let out, but several physicians, nurses and economists have been shifted to Dr. John Cronin's Division of Hospital Facilities, where they will continue to work on Hill-Burton operations.

In other budget-directed changes, the Boston and Washington, D.C., offices of Dr. Cronin's operation have been merged with the New York region. This incorporates into the New York unit all states from Maine to South Carolina and east of Ohio. Another change merges the Cleveland and Chicago offices. A small saving was effected by reducing the H-B engineering staff from 10 to six.

OTHER PROGRAMS SUFFER

Congressional economizers appeared to be more concerned with correcting the U.S.-state fiscal relationships than in saving actual dollars. Every one of the seven institutes of health, devoted primarily to research, received more money for this year than for last. The increases are: cancer, from $17.5 million to $20.2; mental health from $10.8 to $12 million; heart, from $11 to $15 million; dental, from $1.6

to $1.7 million; arthritis and metabolic, from $4.5 to $7 million, and neurology and blindness, from $1.9 to $4.5 million.

REPORT ON V.A. CARE

Hospital and veterans association officials are anxiously awaiting release of the latest report dealing with care of nonservice cases in Veterans Administration hospitals. It is being prepared by the hospitals subcommittee of the House veterans affairs committee, following hearings that concluded in midsummer. (For details on hearings, see August issue.)

It is realized by all concerned that there will be something special about this report. It cannot be merely a delay tactic, designed to keep V.A. regulations unchanged as long as possible. At last the battle lines have been drawn, and this report will have to suggest specific reforms.

Other factors ensure that this report will not be just another in the long list of V.A. studies that unearthed nothing and proposed nothing.

For one thing, the temper of the House veterans affairs committee is changing. Although the members have a great deal of personal respect for the chairman, Mrs. Edith Nourse Rogers, she no longer is expected to have a free hand. In the past, Mrs. Rogers has been criticized for being "too easy" on Veterans Administration officials and uncritical of veterans association witnesses.

Now a number of the younger members of the committee, almost all veterans themselves, are determined that some of the V.A. abuses will be straightened out, and during the next session of Congress. They have shown that on critical issues they have the votes to override the chairman, but they will use this power reluctantly.

Furthermore, the veterans affairs committee, with a well established reputation for protecting the status quo in the V.A., had a narrow escape in the last session. The appropriations committee came within a few votes of inserting in the V.A. appropriations bill a rider that would have sharply curtailed nonservice care. The veterans affairs committee protected its prerogative of proposing legislation only by making a firm promise to the House that it would start doing something about abuses. If Mrs. Rogers' committee coasts along next session, there is no question but what the appropriations committee again will attempt to move into the field of legislation. If this happens, the House almost certainly will support the appropriations committee. Even last session, the House and Senate approved a rider that sharply curtails the dental care V.A. may extend to nonservice cases, despite Mrs. Rogers' personal intervention.

There is another factor also, not quite so tangible but nevertheless of great influence. The last session was evidence that a representative or senator may now openly, and roundly, criticize the Veterans Administration and veterans associations without committing political suicide.

Significant, also, is the fact that American Medical Association now is officially committed to a policy of attempting to get V.A. care limited to: (1) the best possible treatment for service connected cases, and (2) nonservice cases of long term duration, such as tuberculosis and neurological disorders, where the veteran can't afford to pay. The A.M.A. reasons that all other nonservice cases should be the responsibility of the veteran himself or of the community.

In the light of all this, it is only reasonable to expect that the forthcoming report of the hospital subcommittee will mean business.

NOTES:

Fortunately for hospitals, Mrs. Hobby's special assistant for medical matters is firmly grounded in their problems. Dr. Chester S. Keefer, who starts on the job this month, is professor of medicine at Boston University School of Medicine and physician-in-chief of Massachusetts Memorial Hospital. During World War II he became known to many hospital people in his rôle as supervisor of penicillin and streptomycin distribution.

Physicians have lined up with more than 10,000,000 other self-employed persons to ask Congress once more to help them in setting up their own retirement plans. Under present law, employes of corporations are in a favorable position. The corporations may put money into employe trust funds—a form of salary—without paying federal tax on the money. The self-employed, however, must pay the income tax before salting away the money for their old-age protection. Doctors, lawyers, salesmen and scores of other occupational groups are asking that they be allowed to defer tax payments on such money and pay the tax when they receive the pensions.

The same committee that heard these tax arguments also must pass on legislation that the doctors don't want but that the Eisenhower administration does want. It is the new social security plan, which would extend old-age and survivors' insurance coverage on a mandatory basis to virtually everyone in the country, doctors included. Even if no decision is reached next year on the pension proposal, the social security extension bill is certain to come to a vote.

The end of Korean fighting caught the National Blood Program slightly overextended. As a result the Red Cross closed 15 of its own blood collection centers and ended contracts with 17 community blood banks.

Nothing has been done to put into effect recommendations of the special commission that looked into problems of caring for dependents of military personnel. The recommendations, which would extend care and make it uniform, came too late even for legislation to be introduced. However, the military services will attempt to get Congress to go to work on this complicated question next session.

Up for early consideration by the House when the session opens in January will be legislation to shift medical care of Indians from Interior Department to U.S. Public Health Service. It has passed the House committee and likely will clear the Senate committee with no difficulty after the bill passes the House itself. P.H.S., which testified against the plan, now is about resigned to taking over the additional responsibility.

For the present at least, there are no plans to reduce the draft calls for physicians because of the Korean truce. Incidentally, Defense Department promises that use of physicians to help restore and improve South Korea's health services will not mean drafting additional doctors; the assistance will be given in "spare time."

Although the last session was not notable for its generosity toward veterans, it did enact a law extending the three-year presumption of service connection to all types of tuberculosis.

Rep. Carroll Reece (R.-Tenn.) is chairman of the special House committee appointed to investigate tax-exempt foundations, many of them heavy contributors to medical research and hospitals. It is the second such investigation in less than two years. The first started out critical of the foundations but wound up with a generally favorable report.

The Modern Hospital
SEPTEMBER 1953

LOOKING AROUND

Good to the Last Bite

A HOSPITAL administrator we know has forwarded the following correspondence, which we reproduce here without comment, leaving the reader to judge for himself whether it was sent with laughter or with tears:

"I brought my son home from your hospital Thursday," the first letter says. "We were delayed about an hour after the doctor discharged him, because the key to the men's clothing room in his ward could not be found. The nurse in charge finally told us an employe had gone home with the key in his pocket and took our address, promising that his things would be sent to him the next day. They have not been received here.

"Most important is his teeth, both upper and lower plates, and two cards written to encourage him were not given to him until after we arrived to take him home and then not until we inquired about them."

The second letter is dated a week later: "I am returning under separate cover the teeth you sent to my son. They are not his. The day he was dismissed from the hospital he was offered an upper plate that was in a cup in the kitchen of his ward, but he told them he had two plates, and they decided his teeth must be locked up with his coat. When his clothes arrived they sent his lower plate and an upper plate that doesn't fit. Please ask the nurse in charge to make a further search for his upper plate."

The next letter is from the hospital administrator. "Today we are mailing your son's upper plate," this says. "A patient who had been discharged took these teeth instead of his own. We regret the inconvenience and delay caused by our mistake. Thank you for your patience in this matter."

The episode closes with an acknowledgement: "My son's teeth have arrived and I wish to thank you for your diligence in searching for them. He is improving and I feel will make more rapid progress now that he can eat foods requiring chewing. We had about given his teeth up for lost when your letter came saying another patient had taken them by mistake. Many thanks to you."

Circle Route

WHAT with one thing and another, we have spent quite a bit of time in the last month or so looking through old issues of The MODERN HOSPITAL — an experience that has unnerved us, in much the same way a man is unnerved when he comes upon his own tracks in the woods and realizes, suddenly, that he has passed this place before, so he must be lost and going in circles. This feeling was especially noticeable, for example, when we came across an account of the 1913 meeting of the American Medical Association, at Minneapolis.

At that time, the A.M.A. had a hospital section, which, apparently, looked like as good a place as any for the doctors to square off on nursing problems. Reporting a talk made by Dr. Gilman Thompson of New York City, the story said, "Dr. Thompson thought that the training schools were very much more given to teaching bacteriology, urinalysis, voice culture and the functions of the ductless glands than they were to teaching the gentle art of making the patient comfortable in bed."

As it turned out, Dr. Thompson's irony did not go unchallenged, any more than it would today. "Dr. Russell Beard of Minnesota took the opposite tack," our report continued. "The theme of his paper was that nurses must be of a higher order of women to start with, educationally and intellectually, and that the small hospitals which did not have complete nursing services should not be permitted to train nurses at all."

Look, there's that big rock again, and that same funny tree! Anybody around here got a compass?

Drop That Gun!

THE other day a friend of ours who is vice president of a manufacturing company in the hospital industry sent us a letter he had received from a hospital. "As you probably know," this said, "we have a building program on at the ———— Memorial Hospital which will increase our capacity more than 50 per cent. When we increase our bed capacity we must, of course, increase the number of our employes and the amount of supplies. Our records show that in the past three years we have spent $———— with your company. . . .

"You spend money for advertising to bring in new business," the letter continued. "You invest with the Chamber of Commerce to bring new industry which will result in additional business. This appeal is on that same basis. If advertising pays—if an investment to bring new industry to a community pays—then an investment which will increase business by 50 per cent with an old customer is also sound business practice. . . . We suggest an investment in our hospital of 10 per cent of three years' business. We are enclosing a pledge card for your convenience."

Commenting on the letter, our friend said, "The idea seems to be that if you want to do business with an institution, you'd better contribute!" That is precisely the idea, and, judging from the number of these letters we see and hear about, there must be hundreds of hospital administrators and trustees who can see nothing wrong with it—a circumstance that reflects little credit on either their ethics or their economics. An ethical sense that condones such gun-at-head tactics is about equal to an economic sense that fails to understand the ultimate economic consequences in higher prices or inferior products, or both. Furthermore, a man who can write a give-or-we'll-shoot appeal for a voluntary hospital obviously doesn't understand that the most precious thing in the whole voluntary system is its freedom. The doctor whose choice of professional methods or materials is restricted for reasons of business reciprocity isn't much better off than one whose freedom is restricted by bureaucratic regulation. There is no place for backscratching in the hospital, any more than in the practice of medicine.

This is not to say that voluntary hospitals do not need corporate contributions, or that corporations should not make philanthropic donations. No hospital campaign today could succeed, or even come close, without corporate contributions. On the other hand, few corporations are insensitive or unresponsive to soundly based appeals for support of local institutions and programs. In the aggregate, it is estimated, corporate gifts to charitable organizations totaled $300,000,000 in 1952. Some corporation stockholders have objected to such gifts on the ground that they constitute a misuse of corporate funds, but most stockholders take the view that management knows what it is doing when it makes a substantial contribution to a hospital in its own community. Essentially, what it is doing is ensuring the existence of proper facilities to protect the health of employes whose productivity is the corporation's most valued asset. It is also contributing to the strength of a free, voluntary social organism whose effectiveness, in the long run, will measure precisely the distance government will not go toward managing our health facilities. The chances are, however, that a manufacturer in New Jersey who contributes to a hospital campaign in, say, Michigan is not accomplishing either of these purposes. Instead he is probably responding to pressure or offering a bribe for business favors, granted or anticipated, and he and the hospital are both deceived if they think anything good is going to come of it.

Under Par?

FEW people have any idea of how to plan their time," said this little booklet which arrived at our desk, as it happened, when we were planning with a professor friend for a series of articles on how hospital administrators may spend their time effectively. "Few people live with zest or genuine enjoyment," the booklet went on. "They are regretting the errors of yesterday, or worrying about the job or problems of tomorrow. Or they are tired and nervous and under par so that they are incapable of applying themselves to their work. They are just dragging along."

Having thus, and we thought neatly, defined the problem, the booklet then addressed itself to the answer: "If you want to achieve full, zestful living, make effective use of your energy, and get real pleasure out of the day," it said, "here are some simple, step-by-step rules to apply." We turned the page eagerly, prepared to wire our professor friend that the articles would not be needed, since the answers were already at hand.

"Set your alarm clock ahead 10 minutes," the book said, reviving an old dodge and awakening a suspicion that the cure for that tired, nervous feeling might not be so simple, after all—a suspicion that deepened to mistrust when we discovered that the 10 minutes were to be spent stretching and inhaling. "Stretching will do you more good than the extra sleep," the book said, stating a proposition that is doubtful on the face of it and leaves us, at best, right where we were before we tampered with the alarm clock.

"Make it a rule to sit down for your breakfast and eat it without haste," the book continued, forgetting that we have already used up our 10 minutes leeway revving up our lazy lungs, and are now in a hurry, as usual. "Be on time," it continued severely. "When you are always racing to work or trying to catch up with your schedule, you are in a constant state of tension."

The trouble is lack of organization and planning, the author explained. "You haven't learned how to budget the hours and minutes," he said. "Being rushed is merely a sign of bad management. Plan to do the unpleasant things as soon as you can and get them out of the way—a particular work problem, a bill you have put off paying, etc. When they are done, you will experience a sensation of relief, and also the feeling of strength and self-reliance that comes with having accomplished unpleasant jobs."

Our disillusion complete, we put the book aside and hunted through a pile of particular work problems and unpaid bills until we found a memo pad. "Hurry up with those articles, Professor," we wrote our friend. "Emphasize rules for full, zestful living. Everybody tired, nervous, under par."

The Clinical Center Didn't Just Grow

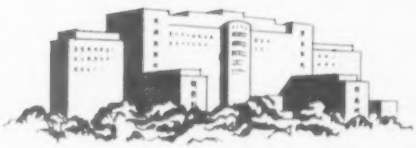
From drawing board to dedication,

it was put together painstakingly

over a period of six years by men who see it

as the center of the war on chronic disease

Circle drive to main entrance.



JANE BARTON

PROBABLY the most surprised people in Bethesda, Md., the day the Clinical Center of the National Institutes of Health opened were the individuals who were responsible for its opening. For years they had thought and talked of little else; they had persevered in the face of delays, foul-ups, shortages of material, and the unsettling effects of a change of administration; they had seen the Center take shape, first in the minds of a distinguished group of planners and, gradually, in concrete, brick and limestone; they had sweat out the horrid moment when it seemed that the housekeeping porters might have to appear pantless at the grand opening because a truck bearing the pants had vanished somewhere along the road. But until June 19 when official word came that "Mrs. Hobby will dedicate the building July 2 and we will move the first patients in on the 6th," they didn't really believe it. The Clinical Center was in business.

How it got into business is a fascinating study in logistics, expressed succinctly by Albert F. Siepert, executive officer of the National Institutes of Health, in the words: "Six years to plan it, five years to build it, and three years to staff it." Neither Mr. Siepert nor Richard Henschel, executive officer of the Clinical Center, nor Donald L. Snow, chief of the Research Facilities Planning Branch, the three men upon whom execution of the plans largely devolved, sees anything very remarkable about purchasing, assembling and allocating nearly $10,000,000 worth of equipment, or about recruiting the professional and nonprofessional personnel needed to operate the Clinical Center. They purchased more than a million articles of equipment and supply; they executed 2500 purchase orders representing 100,000 locations in the building; they kept track of every single item delivered to the central warehouse (connected by tunnel to the Clinical Center which serves the whole N.I.H. reservation); they transferred as much equipment as was required to open the first patient units and the supporting services, such as nursing, dietary, housekeeping and the like. And, of course, they had to employ qualified department heads to help them accomplish their task. All of

Small pools on either side of the main entrance symbolize Center's spirit and purpose. They represent the pool of Bethesda where Christ healed the cripple.

South view of the 14 story structure overlooks wooded, landscaped grounds. Patients are housed on this side; nursing units in the center, laboratories on the north.

DR. JOHN A. TRAUTMAN

ALBERT F. SIEPERT

RUTH JOHNSON, R.N.

DONALD L. SNOW

this, they regarded as purely a matter of mechanics.

After all, it was their job to translate into action (budget and personnel permitting) the ideas laid down by the planners, including Drs. Thomas Parran, Rolla E. Dyer, Leonard Scheele, Jack Masur, Norman Topping, W. H. Sebrell, and John A. Trautman. These ideas were very specific and equally complex to carry out: To construct a 500 bed hospital completely surrounded by laboratories so that the findings of research scientists can be brought directly to the patient's bedside for study and evaluation, thus eliminating the usual time lag between discovery and application.

It was quite a job, and one that was made no easier by the necessity for reconciling the needs and views of the laboratory personnel with those of the hospital staff. Unlike the Light Brigade, which had only to charge ahead and do or die without bothering about reasons, the executive officers had not only to understand the reasoning behind the design of the Clinical Center but also to explain that reasoning to sometimes fretful department heads—and stay alive, at least until the Clinical Center opened.

As a case in point, immediately outside every third laboratory bay is an overhead shower to be used by the laboratory workers in the event that they are accidentally splashed with acid or their clothing has caught fire. But nowhere are there any floor drains to carry off the water. When the executive housekeeper wondered aloud at the oversight, she was informed that it was no oversight. The laboratory areas were intended to be highly flexible and floor drains would have interfered with that purpose. Hence, it was decided that when, as and if the showers had to be used, the housekeeping department would go into action with the wet pickup machine. It was a perfectly reasonable decision from the standpoint of the laboratory planners, though the housekeeper still wonders about the effect on asphalt tile floors.

The dual function of the Clinical Center and the need for integrating hospital and laboratory complicated every phase of the planning. The scientists had to be provided with every possible facility for the pursuit of their researches and at the same time had to be brought into close contact with one another and with the patients, while the patients, on whom everything centers, had to be made comfortable and happy while the doctors ponder their problems.

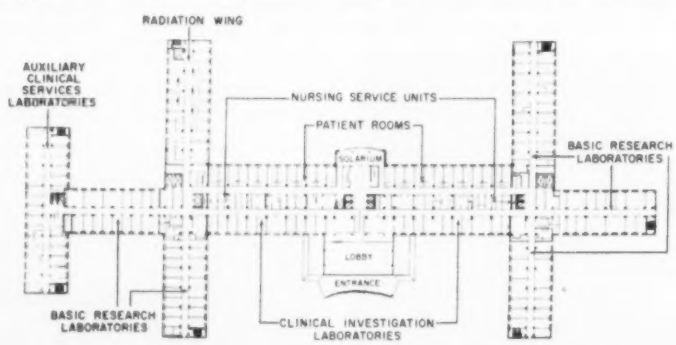
In both endeavors a high degree of success has been achieved. The laboratories, which occupy two-thirds of the building, have been designed to afford the utmost utility and flexibility and to meet the requirements of the most exacting scientist. The flexibility is made possible by demountable steel partitions which are literally "subject to change without notice" as the changing needs of the research programs require.

How often they will be changed nobody around the Clinical Center will predict. Next to "flexibility" the most popular word in the lexicon of the National Institutes of Health is "permissive." The basic philosophy of the Clinical Center is to give the investigators freedom to work out their ideas without any restrictions except those necessary to protect the patients from the hypodermic-happy type of researcher who turns up occasionally in even the best regulated institution.

The well-being and comfort of the patients was the paramount concern of everyone connected with the planning of the center, as is evident from the layout and furnishings of the patient areas. It will be a churlish individual indeed who complains about his surroundings. In fact, Clinical Center officials are wondering in all seriousness if they won't have more trouble getting certain patients out than they will getting the patients they really want to stay in for study.

The airy, colorful, nonhospital atmosphere was based on a hard-headed assessment of economics, research needs and human nature. Most patients will be needed for long periods of study—from six weeks to three months on an average. Many will not actually need hospitalization. Many will be asked to return at regular intervals over a period of years for inpatient follow-up tests and observation. The

Floor plan shows relation of patients' rooms to service units and laboratories.



PATRICIA M. BOYER

EDITH JONES

RICHARD HENSCHEL

Some of the persons involved in putting the complicated Clinical Center in business. They had to integrate hospital and laboratory services at every point.

huge investment in each patient would be lost if he left before his part in the study was completed. But the visitor to the Center, gazing out over the rolling Maryland countryside from a solarium that would do credit to a luxury hotel, can readily see why a patient who has exchanged a dreary city apartment for the attractive quarters and carefully planned recreational facilities of the Center will not want to be dislodged any sooner than is necessary.

The concern of N.I.H. officials for the patients' welfare was matched only by their concern for the budget. Admiring comments on the handsome interiors and furnishings evoke an immediate explanation that the costs were lower than one would expect because the purchasing could be done on such a vast scale. Mr. Henschel gleefully points out, too, that the furniture in many offices and public areas was made at the federal narcotics farm in Lexington, Ky., at a surprisingly low cost.

This anxiety to avoid even the appearance of extravagance is understandable in government officials who have had to justify the expenditure of every dollar all the way up to the eagle-eyed congressional appropriations committees. To Mr. Snow and his staff, working first with Dr. Jack Masur, the guiding genius of the Clinical Center from 1948 until he was made assistant surgeon-general in 1951, and then with his successor, Dr. John A. Trautman, fell the formidable task of building the budget.

In a speech given at Columbia University, Mr. Siepert explained that ". . . the first task was to standardize on a limited number of fixed equipment items and print these in a catalog along with certain basic guidelines on space layout. Each laboratory supervisor then planned his own space, selecting the items from the catalog which best fit his needs or preferences. . . . This does not produce standardization of the research area into a few typical layouts; in fact, each module may be unique, but its component parts are standardized, largely interchangeable, and completely salvageable when the module needs to be changed for a different occupancy."

The lists submitted by the laboratory representatives were painstakingly collated and priced by Mr. Snow and then forwarded to the central purchasing and supply branch. Again, in Mr. Siepert's words: "We developed an estimated unit module cost for each type of laboratory area based upon a composite inventory of equipment in representative laboratories now in use at N.I.H. The unit costs were multiplied by the number of modules of each type in order to obtain the estimated total required for (1) fixed equipment, (2) scientific apparatus, and (3) other movable equipment and initial supplies. These data have been most helpful in determining the original appropriation requirements. They were also used as the basis for dollar allocations within which the occupancy planners of the several Institutes could determine their total equipment needs."

The same general procedure was followed for the hospital areas. A budget was set up for each department. Department heads submitted lists of materials, supplies and personnel needed to operate effectively, and then the two were reconciled — as nearly as possible.

In some cases, notably the nursing department, a beautiful rapport has been achieved. Ruth Johnson, chief nurse of the Clinical Center, who is in the commissioned nurse corps, is probably the only nursing director in captivity who will admit to being perfectly satisfied with the physical setup of her department. "They haven't said No to a single essential we needed for the patient areas," Miss Johnson explained, with the cheerful air of one who hasn't had to scream for what she wanted. Possibly the reason for this happy state of affairs is that the screaming was done for her by Lois Gordner, also a commissioned officer in the Public Health Service, who was called in as consultant early in the proceedings. One of Miss Gordner's major contributions was the provision of facilities for isolation technic. Until her arrival on the scene, the planners had regarded them as quite unnecessary. Indeed, they steadfastly refused to consider them until Miss Gordner stated, in effect: "No isolation facilities, no nurses." The isolation unit, complete with decontamination area, is on the eleventh floor.

Staff-wise, Miss Johnson is also well pleased. Although she refused to commit herself on the precise number of nurses she had in proportion to those she would require ultimately, she indicated that recruitment was progressing nicely. The combination of a beautiful new building and the unusual challenge presented by the Clinical Center's nursing operations has proved so attractive that Miss Johnson can afford to be selective, particularly in the case of the chief nurses. Each of the eight chiefs (one for each of the six Institutes, one in charge of operating rooms, and one in charge of admissions and follow-up) will work directly with the clinical director of her special institute and will be permitted a great deal of leeway in running her own service, under the general supervision of Miss Johnson. In addition to the graduate staff the nursing service will include licensed practical nurses and attendants trained on the job.

Staffing and recruitment presented rather more of a problem to other department heads than they did to nursing. The housekeeping department, in particular, suffered from the "freeze" of personnel and funds ordered for all government agencies by

Left: Furnishings in rooms for ambulatory patients (which look like something out of Washington's Statler) were surprisingly inexpensive. Above: A typical room for bed patients.

the Bureau of the Budget in February —just when the executive housekeeper, Patricia Boyer, was ready to recruit the staff needed to open the building. And although Mrs. Hobby strove mightily with the budget director to persuade him to make an exception in the case of the Clinical Center so that work might proceed on schedule, the ban was not lifted until the middle of April.

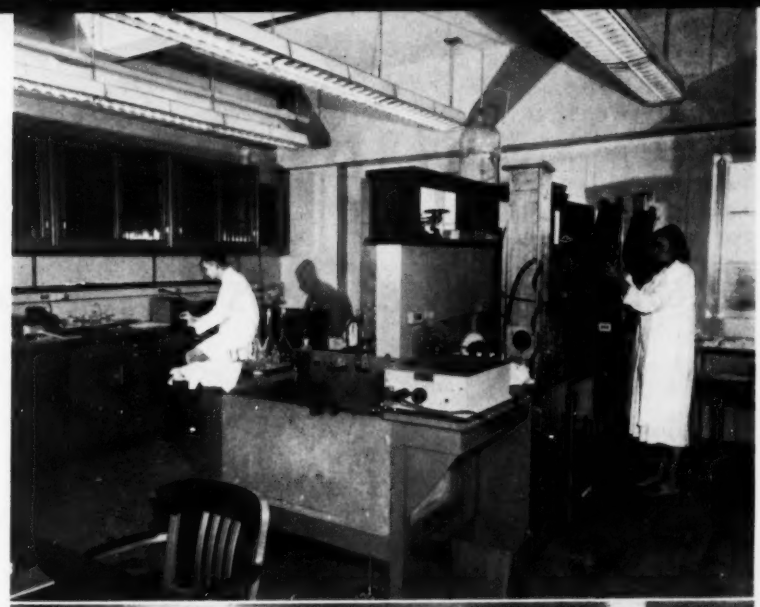
Staffing a housekeeping department for a new hospital is difficult at best, the chief difficulty being that no one but an executive housekeeper can understand why such a large crew is necessary long before the building is even opened: That the cleaning isn't just a one-shot operation to be done at the last moment, but must be done over and over again as the workmen move from place to place; that many men and many hours of labor are required to uncrate furniture and equipment and put them in position, and, finally, that even though a floor or division may be only partially occupied, the whole area must be maintained as if it were in full operation. After all, it is not within the executive housekeeper's province to tell the clinical directors to keep their dirty shoes off her nice clean floors. She must be prepared to clean up after them—whenever and wherever they choose to go.

Mrs. Boyer's first task when she reported for duty in August 1952 was to review the budget that had already been set up for the department and make such adjustments in the estimates of personnel, equipment, maintenance materials and supplies as she considered necessary for efficient operation. Somewhat to her surprise, her revised figures on machines, equipment and supplies were accepted after extensive revision and justification. As has been mentioned, her major difficulty was personnel, particularly the supervisory staff. Mrs. Boyer, like all experienced housekeepers, knows that a housekeeping department is only as good as its supervisors but she sometimes has trouble convincing personnel officers of that fact. Her first request for supervisors, for example, was met with the suggestion that she accept a couple of charwomen who happened to be available. Mrs. Boyer's outraged howls could be plainly heard in Harrisburg and the suggestion was hastily withdrawn. But Civil Service officials, who have never quite grasped the implications of executive housekeeping, are still a little hurt by her intransigence.

Fortunately, Mr. Henschel agrees that housekeeping is a function that requires both skill and training, and with his tactful connivance, the crisis was resolved happily with the acquisition of two able women who have an excellent understanding of their jobs.

When the Clinical Center is in full operation Mrs. Boyer hopes to have one housekeeper for each floor. She will need them in order to do an adequate job inasmuch as the housekeeping department not only is responsible for maintaining patient areas and public spaces but, except for certain special sections, must also keep an eye on the entire laboratory area, even though the laboratory personnel is expected to do its own housekeeping. She will need supervisors, too, to carry out the employe training programs which will embrace not only routine housekeeping procedures but special technics that must be followed by the housekeeping maids in psychiatric and infectious disease units. As teaching-

The colorful, beautifully furnished solariums are designed for visiting, reading or just sitting and looking out over the hills of Maryland.



Top. This laboratory occupies two of the 12 by 20 foot modules, with the work area in the center. Utility service lines extend out from vertical risers. Below: The main kitchen is based on a plan for decentralized tray service for 500 patients and cafeteria service for approximately 2000 employes.

minded as the rest of her associates, Mrs. Boyer expects to work closely with the nursing and dietary departments so that there will be a minimum of overlapping and friction and her employes must be trained along these lines.

The integration of all services, which is the thesis on which the Clinical Center was built, is nowhere more apparent than it is in the setup of the food service department. To patients who are hospitalized over long periods the most important hours of the day are meal hours. They want good food attractively served and aren't particularly interested in vitamins and calories. To the scientists, however, the most important aspect of food service is the relation of nutrition to the patient's disease and ultimate recovery. So the dietary department was designed with both these needs in mind. From the main kitchen adjacent to the employes' cafeteria on the ground floor, food is dispatched on carts to branch kitchens on the upper floors. These are equipped with hot plates, toasters, coffee makers and other devices necessary to the preparation of breakfasts, nourishments and special diets. By thus partially decentralizing the food service N.I.H. officials hoped to solve the age-old problem of getting food to the patients at the right time and the right temperature. Because extensive research will be carried on in regard to problems of metabolism, special facilities are provided for the meticulous preparation of food for patients being studied.

To carry out the essential need to make the patients' stay as enjoyable as possible, an attractive dining room seating 16 persons is located on each floor for ambulatory patients. Selective menus are offered to all patients, even those on special diets. If roast beef is scheduled for the day, then, if possible, patients on a salt-free diet get roast beef, too—without salt. Mental patients will also have a chance to exercise some selection of their food, instead of having it thrust at them. They will make their selection as a group a day in advance so that they will be relieved of the necessity for making a spot decision. Thus the food service will be as much a part of the treatment of mental patients as it will of patients with metabolic diseases.

The dietary department is responsible for the distribution and collection of trays, while the nursing department prepares the patients for meals, feeds them when necessary, and supervises them at all times—even in the dining rooms. Only in the infectious disease units will nurses distribute trays.

Responsibility for the success of the food service department rests with Edith Jones, the chief nutritionist. A cheerful and well organized soul, Miss Jones bobbed out of the maelstrom of budgeting, buying, job analyses, records and employe manuals in which she had been swirling for months to give a careful and detailed explanation of the workings of her department to a reporter, without showing the signs of strain or irritation that might reasonably have been expected. Asked whether she is satisfied with the setup of the department, she grinned and replied that there were things she wished she could change—but, after all, "You just can't please everybody and I think they've done a darned good job."

Miss Jones' comment sums up the situation very neatly. "They," meaning planners and executive officers alike, took on a prodigious task and if they haven't succeeded in pleasing everybody, it is conceded that they have done a darned good job.

Tissue Committee Gets Down to Essentials

ROBERT S. MYERS, M.D.
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Representative, Joint Commission on Accreditation of Hospitals

THE tissue committee, fostered by the American College of Surgeons and adopted by the Joint Commission on Accreditation of Hospitals, is the newest member of the hospital family. This fledgling is just beginning to make the acquaintance of medical staffs of many accredited hospitals and, at first glance, it may not be regarded as an unmixed blessing by all physicians. To those who have seen it work, however, the tissue committee has already demonstrated its present worth and its future promise. Like any infant, the tissue committee must be lived with to be appreciated, and must be nourished to be effective.

RATES SURGEON'S COMPETENCE

Simply defined, the tissue committee is a committee of the medical staff of a hospital, which evaluates the surgery done by the medical staff, and rates the competence of each surgeon on the basis of his performance. The tissue committee is one answer by the medical profession to the problem of unnecessary surgery and is the best known method of providing adequate control of surgery done in our hospitals. It is a prime example of self-discipline by the medical staff, and is the first step toward an indicated advance in hospital medicine—the complete medical audit.

In order that the tissue committee may be made an effective part of the hospital organization some understanding must be had of its organization, its duties, its privileges and its limitations. Such a discussion will be presented here with no attempt to provide the particular details of how to bring such a committee into being.

For the proper functioning of the tissue committee, several essentials must be present:

1. A cooperative medical staff which desires to have its surgical work audited, and is willing to perform this often unpleasant task.

2. A tissue committee, composed of appointed members of the medical staff who are responsible to the executive committee and the medical staff.

3. A pathologist who is competent, honest and forthright. He should preferably not be the chairman of the tissue committee.

4. The requirement that all surgical tissue shall be sent to the pathologist for examination.

5. An executive committee and medical staff which are willing to discipline those surgeons whose work is found to deviate consistently from accepted standards.

Let us consider in more detail each of these essentials.

1. There can be no effective tissue evaluation if the surgeons of the medical staff are reluctant to have their work scrutinized and evaluated or are unwilling to be criticized and disciplined. The reluctance of a few members of medical staffs to accept evaluation of surgical tissues and procedures is sometimes based on their fear that this will interfere with the individual physician's freedom of practice. It is a fear, sometimes, that treatment will be dictated by an outside agency which might control the activities of the surgeon through hospital accreditation. It is a fear, often, that the administrators of hospitals will attempt to dictate the actions of medical staffs and impose control of the profession by laymen. It is a fear, usually, that colleagues on the medical staff may try to harass and restrict the activities of the individual physician for purely personal reasons. These fears must be answered to gain the support of the medical profession, and the following assurances can be given:

The individual surgeon is free to determine the specific treatment for his patient within the limits of good surgical standards which are recognized and advocated by the medical profession as being in the best interest of the patient. To protect both the patient and the physician, controls are a necessity and must be observed.

The controls are applied by the tissue committee of each individual hospital, not by an outside agency. It is self-government, pure and simple.

BOARD IS RESPONSIBLE

When the medical staff applies its own self-discipline adequately, lay administration has no reason to interfere with medical staff matters. But it must be remembered that the governing board is legally and morally responsible for the conduct of all hospital affairs, including those pertaining to the welfare and safety of the patient, and the governing board must be reassured that all precautions are being taken to safeguard the patient.

Criticism of the surgical work of an individual by his colleagues must not be destructive, and must be supported by facts presented by the tissue committee. It must be constructive.

If the criticism must be constructive, it also must be honest. Mutual admiration of the efforts of one another robs the tissue committee of any value.

ESSENTIALS OF AN EFFECTIVE COMMITTEE

1. ***A cooperative medical staff***
2. ***A tissue committee composed of staff members***
3. ***An honest, forthright, competent pathologist***
4. ***Examination of all surgical tissue***
5. ***Good disciplinarians on the committee***

2. To be effective, the tissue committee should be composed of physicians who can properly evaluate the surgical work of their colleagues. These members must be willing to spend a considerable time each month, assessing the records and tissue reports and designating those cases which show unjustified surgery or an unjustified removal of normal tissue. They must be willing to inform individual surgeons, through proper channels, of their deficiencies. They must regard their service as a long-range program which will enable surgeons to improve the caliber of their surgical work from month to month and year to year. Unless physicians are found who are willing to discharge all these functions in a time consuming and difficult assignment, the tissue committee will be stillborn.

3. We are fortunate that our hospitals have so many honest, capable and forthright pathologists to examine and classify the surgical tissues. Unless all tissue is honestly described and properly diagnosed, the clinicians of the tissue committee will be unable to evaluate the surgery properly. There is no place in modern medicine for such diagnoses as "fecal appendicitis" (which is a normal appendix containing feces); "chronic appendicitis" (in the appendix which shows no disease); "chronic salpingitis" (in tubes which are patently not inflamed); and "fibrotic uterus" (in a uterus which is normal in size and contains the usual minimal fibrosis accompanying age and repeated pregnancies). Surgeons should not expect or receive such aid and comfort from the pathologist. The pathologist should neither give such aid voluntarily nor be coerced into making such diagnoses. The reason given occasionally for such camouflage is that the patient cannot collect on his medical insurance policy if a diagnosis of "normal tissue" is returned. This is dishonest and cannot be tolerated.

The pathologist who is in active attendance at the hospital has a vital rôle to play as a member of the tissue committee, both in selecting those cases demanding review by the committee, and in presenting his report on all tissues removed. However, usually it is not in the best interest of either the committee or the pathologist to have him serve as chairman. There are two reasons for this:

The final evaluation of each case must be a clinical one, and he is not a clinician.

The pathologist may be regarded as a "hatchet man" by those surgeons who attempt to place all the responsibility on him for decisions of the tissue committee. There have been instances where young and capable pathologists have suffered job insecurity through efforts of dissatisfied and powerful surgeons.

4. Brief mention only need be made of the fact that all tissue removed at operation must be sent to the pathology laboratory. This is essential to protect the patient.

Experience has shown that unnecessary surgery occurs most frequently in certain types of surgical procedures, such as appendectomies and gynecological surgery. Careful scrutiny of all tissue removed in these operations, plus evaluation of all surgery in which normal tissue is removed and all surgery in which no tissue is removed, as well as those cases in which there were marked differences between preoperative and tissue diagnoses, will ensure proper evaluation of the surgical work.

Operations involving the reproductive organs occupy a major portion of the review by the tissue committee. Gynecological surgery offers the most fertile field for unnecessary surgery for the following reasons: (1) History is often obscure and difficult to evaluate; (2) radiographic and laboratory examinations are usually unrevealing; (3) physical examination is frequently inconclusive, and (4) pressure is exerted on the profession by the public to perform some definitive surgical procedure for relief of symptoms, real or imaginary.

A decision as to clinical justification for the removal of normal pelvic organs and physiological variations of the ovaries (such as the corpus luteum) must be made by the committee. Operations in which no tissue is removed, such as uterine suspension, lysis of adhesions, and exploratory laparotomy, must be carefully evaluated and their performance justified by clinical indications to be acceptable. And finally, the removal of normal tissue in any operation or a marked discrepancy between the preoperative and tissue diagnoses must be referred to the tissue committee for its evaluation.

So far, no insurmountable obstacles to the functioning of the tissue committee have been mentioned, and perhaps there are none. However, it must be recognized that there are certain gaps in our medical knowledge at present which make valid interpretation of tissue statistics extremely difficult. Some hospital statistics are based on superstition and have little basis of fact to support them. Need I mention more than the hospital "net death rate," which is based on all hospital deaths over 48 hours? Why 48 hours instead of 24 or 72 or 96 hours? Frankly, I do not know, unless it is a throw-back to early hospital days when the profession had little more to offer the patient than purging, bleeding and hot stupes. If he lived more than 48 hours it was thought that his subsequent death should be charged to the physician from there on out. What is the justification for a postoperative death rate of 1 per cent, which has a

numerator of all deaths within 10 days of operation (why not 11 or 15 days or the entire hospital stay of the patient?) and a denominator of all surgical operations done in the hospital. It seems entirely unrealistic to divide brain tumors and abdominal malignancies by teeth extractions, ligation of varicose veins and D & C's. Such statistical reasoning gives a false picture of true surgical mortality.

Present "justifiable" rates for removal of normal tissue are likewise unknown. It has been said for years that from 10 to 15 per cent of normal tissue removed is justifiable. Some strike an average and hold out for 12 per cent, while those who are more generous raise the figure to 20 per cent. The simple truth is that we have no exact idea at present as to just what comprises a justifiable normal tissue removal rate. But we hope to find out in the near future by studying a large group of hospitals of all sizes, of various locations and of various staff compositions.

Perhaps the most frequent deficiency which works to the disadvantage of the individual surgeon, and to the tissue committee evaluating his work, is the inadequate documentation, in the patient's record, of facts of the history and physical examination. Little credit accrues to the surgeon who fails to record a long history of disabling uterine bleeding and previous repeated attempts at conservative therapy when hysterectomy produces a normal uterus. It is hard to defend the gynecologist who performs a vaginal hysterectomy for alleged uterine prolapse, and who records no pelvic examination, especially if the patient is young and her uterus is normal according to a competent pathologist. On the other hand, even the most complete history and physical examination will not protect the surgeon who performs a uterine suspension on a young girl with vague and nonspecific symptoms of headache and nervousness and generalized body pains, or who does a tubal ligation simply because the patient desires no further pregnancies. It becomes difficult to justify the needless resection of the physiological corpus luteum of the ovary in the course of other abdominal surgery, and the removal of the so-called "chronic appendix" for the definitive treatment of duodenal ulcer which has been proved by x-ray examination.

Experience has shown that a monthly tissue evaluation, honestly and conscientiously made, results inevitably in a reduction of unnecessary surgery and the removal of excess normal tissue. This presupposes, of course, that deviation from standard surgical technic and judgment is explained to the responsible surgeon in a constructive manner, and that disciplinary action is authorized and used, if necessary. Fortunately, the vast majority of all physicians doing surgery are primarily concerned in the welfare and safety of the patient, and they welcome an opportunity to increase the value of their services to the patient.

The successful functioning of the tissue committee will ensure hospital patients of the best possible surgical care. It is now a required committee in hospitals doing surgery which hope to qualify for accreditation by the joint commission.

Show Them What Nursing Costs

SINCE many persons are inclined to compare the charge for a hotel room with the charge for a hospital room, it might be advisable for hospitals to consider splitting their "room charge" into from two to four separate charges with their proper designations.

As long as we have inflation, wages and rates will have to be increased. Hospital employes are entitled to the same living standards as are others in the community. Nursing department salaries and wages are one of the largest items included in the hospital room charge. Dietary expense is another, and medical and surgical service, while usually not as large, is still another charge included in the room rate.

If a ward bed charge is $14 daily, the patient thinks of it as a high charge. Were this charge broken down into four separate charges it might be more readily accepted. True, it would mean more postings and more work for the business office, but it might be better public relations to bill patients as follows:

Ward Bed	$2.50
Dietary Service	$3.50
Nursing Service	$6.50
Medical & Surgical Service	$1.50
TOTAL	$14.00

Similarly, if a private room charge were now $24, it might be more readily accepted by Mr. Patient if presented on the bill as follows:

Room	$12.00
Dietary Service	$ 4.00
Nursing Service	$ 6.50
Medical & Surgical Service	$ 1.50
TOTAL	$24.00

As long as the scarcity of nurses continues and inflation is with us, nursing department salaries and wages will continue to spiral. If a hospital gives, on an average, three and a half hours of nursing time to each patient and nurses are paid $1.50 per hour, it would seem intelligent and realistic to make a charge of $5.25, the staff nurses' salaries, plus the cost of salaries and wages of nursing administrative and auxiliary nursing personnel figured on the same basis.

If it were felt undesirable to break down the existing room charge into four separate charges, it might be broken into two charges. For example, if the semiprivate charge were $16, it could be charged to:

Room and Meals	$ 8.00
Nursing & Medical Service	$ 8.00
TOTAL	$16.00

Since the public insists on the comparison with hotel charges, an American Plan rate for room and meals in the hospital should have popular appeal. For example, a $20 room charge for a private room could be:

Room and Meals	$12.00
Nursing & Medical Service	$ 8.00
TOTAL	$20.00

We in hospitals find it difficult to educate the public in the matter of hospital costs and, while it may seem to be "beating around the bush," perhaps we are missing the boat by not coming around to the public's way of thinking and presenting bills that people can readily comprehend.

A detailed explanation of the various charges could be printed on the back of the patient's bill.—ROLAND EATON, *Samaritan Hospital, Troy, N.Y.*

Rockford Memorial Hospital provides

A Fresh Solution to a Basic Problem

FRED C. KRAMER
Design Coordinator
Perkins and Will, Architects and Engineers
Chicago

THE Rockford Memorial Hospital, Rockford, Ill., is an entirely new project planned to replace one of Illinois' oldest existing hospitals. The original plant had its origin in an old residence, in the heart of town, in 1883, and has suffered from too many annexations without benefit of an overall growth pattern to follow. Thus, it became a rambling, uncoordinated patchwork of worn-out buildings which have served far beyond their time.

A firm concept for new quarters began as far back as 1947, with the purchase of a 15 acre site on the extreme north edge of the city, and the idea of constructing a new fireproof 200 bed general hospital building as the first portion of a complete new medical center for this area.

The plan study phase began when Hendrik P. Maas was retained as architectural consultant to the building committee. The next step, since this was to be a relatively large private project, was to select the architectural staff, *i.e.*, the two firms of Hubbard and Hyland of Rockford, Ill., and Perkins and Will of Chicago and New York. The former had served the hospital well during many past projects, and was well acquainted with the existent problems at the old site. The firm of Perkins and Will, on the other hand, was not inhibited by previous tenets, since it had never before built a hospital and consequently was free to explore and develop new concepts. This two-office association developed into a well integrated team.

The ultimate building will not reflect all of the schematic layouts and materials that the associated architects originally proposed; however, it definitely presents a clean, fresh solution to the basic problem of designing a hotel for people who are ill.

The last sentence is the cue to the first problem the architects set out to solve. Since a hotel is composed of rooms as the basic element, a room which would impart an intangible cheer-therapy during the patient's stay was in order. It was resolved quite early in this study that a speedier recovery from illness and greater patient safety would result from a pleasant *single* room fully equipped.

In Rockford this highly controversial problem was solved in a unique

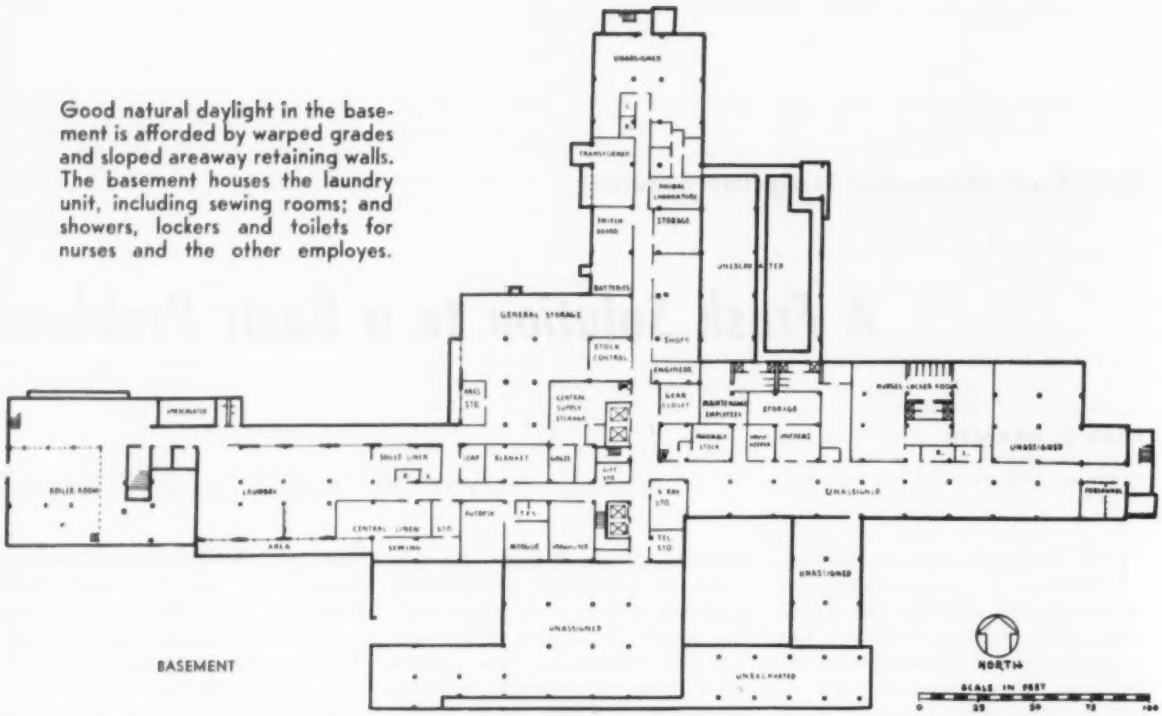
COST DATA

Total cost for original 200 beds	$4,000,000.00
Cost per bed	20,000.00
Cost when expanded to 268 beds	4,400,000.00
Cost per bed (at 268 beds	16,000.00
Total square feet for 200 beds	170,000
Square feet per bed (to be revised when hospital is expanded to 268 beds)	850
Cost per square foot	$ 23.33

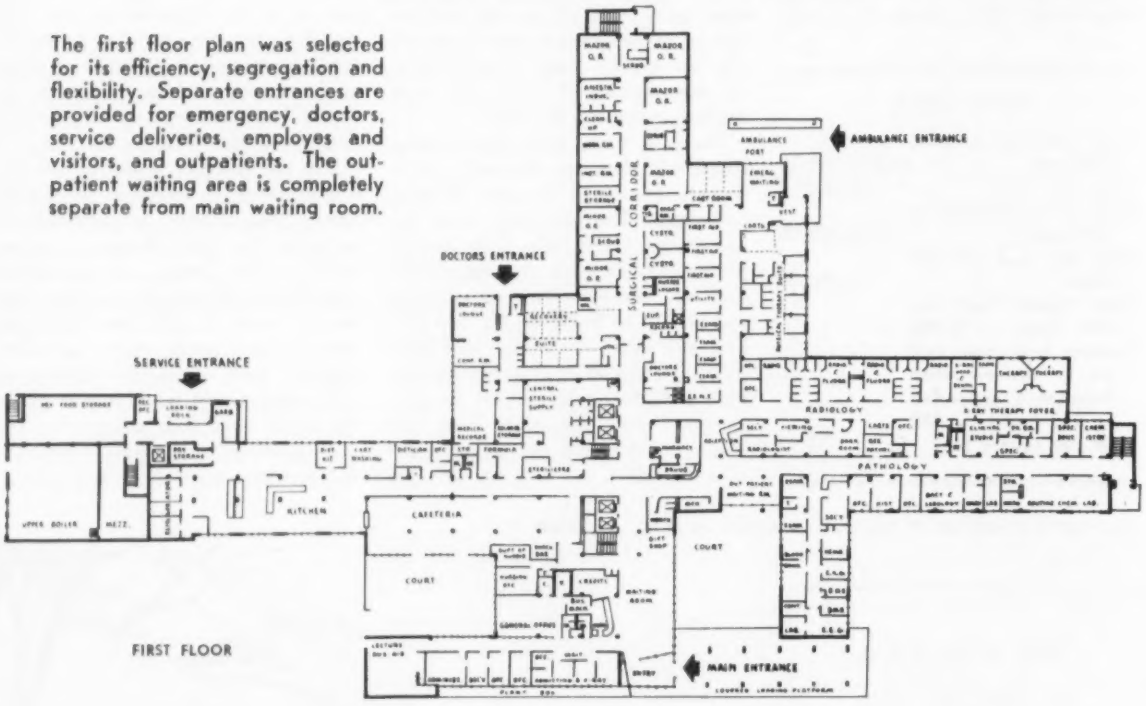
ARCHITECT'S RENDERING OF ROCKFORD MEMORIAL HOSPITAL, ROCKFORD, ILL.

THE MODERN HOSPITAL OF THE MONTH

Good natural daylight in the basement is afforded by warped grades and sloped areaway retaining walls. The basement houses the laundry unit, including sewing rooms; and showers, lockers and toilets for nurses and the other employes.



The first floor plan was selected for its efficiency, segregation and flexibility. Separate entrances are provided for emergency, doctors, service deliveries, employes and visitors, and outpatients. The outpatient waiting area is completely separate from main waiting room.

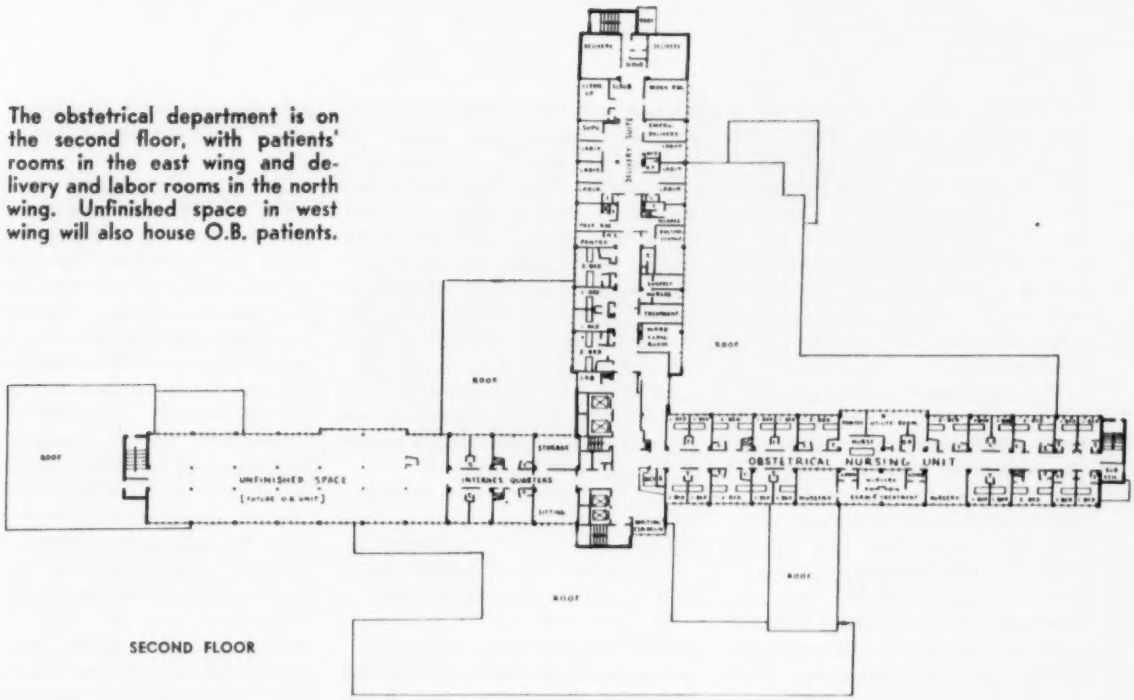


way. An initial study phase which spanned about a six month period focused all the attention on the planning of bedroom designs only. The architects then presented what appeared to be a compromise solution embodying the best features of all the previous so-called standard room plans. From a group of about 10 designs, the innovation of a literally translated semiprivate room emerged. Full-size "mockups" were built of this new semiprivate room, as well as the design of the private room complement.

The accompanying sketches of the solution make it appear quite simple now. Just take the average two-bed hospital room, with the two beds in line and parallel to the window wall, then swing the entire room around 90 degrees and place the beds end to end, and make the long wall the window wall. The room is still deep enough, however, to change the position of the bed, if required by the attending physician or for use with traction apparatus. The convenience outlets and other built-in features are placed to accommodate each bed position equally well.

This typical semiprivate room contains a wall to wall window treatment extending from the ceiling to 27

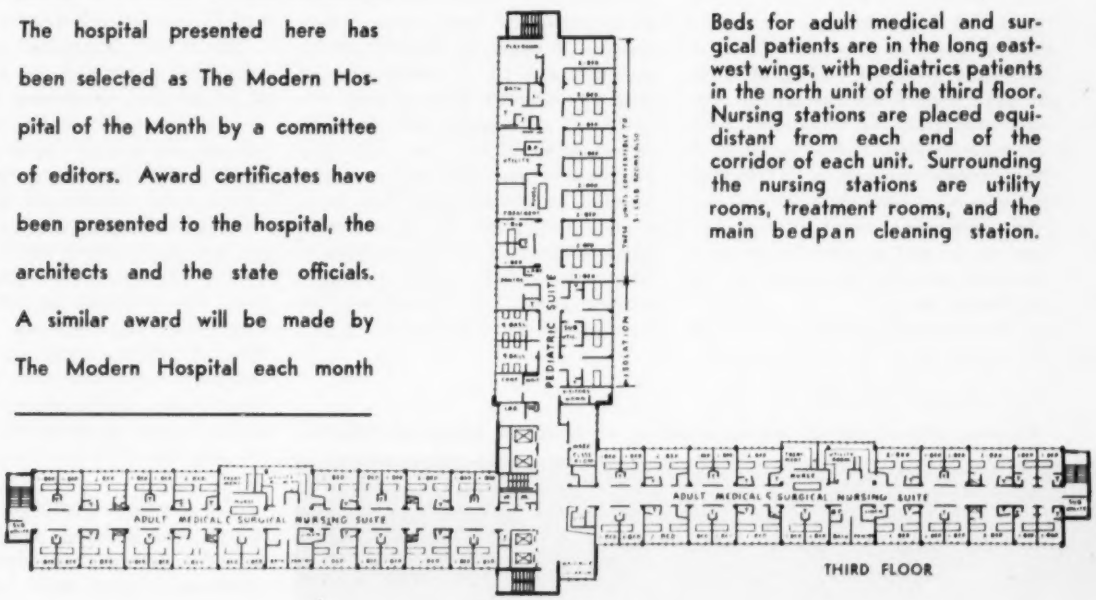
The obstetrical department is on the second floor, with patients' rooms in the east wing and delivery and labor rooms in the north wing. Unfinished space in west wing will also house O.B. patients.



SECOND FLOOR

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month

Beds for adult medical and surgical patients are in the long east-west wings, with pediatrics patients in the north unit of the third floor. Nursing stations are placed equidistant from each end of the corridor of each unit. Surrounding the nursing stations are utility rooms, treatment rooms, and the main bedpan cleaning station.



THIRD FLOOR

inches from the floor. This height above the floor forms a desirable wide window stool seat and storage shelf. A curtaining system hung from a new type of track, which is flush mounted to the ceiling, provides not only diffusion draping of the window wall but also a divisioning of patients from each other for treatment purposes. It is similar to the usual ward divisioning, without the objectionable suspended pipe rail curtain tracks, and though it does separate one patient from the other, each still has access to the private toilet, lavatory, built-in features and one-half of window wall. The windows themselves are aluminum and designed for draft-free ventilation of the lower in-swinging hopper vent, and 180 degree pivoted, muntin-free picture section above the hopper vent. This upper section of window not only provides a good unobstructed view but is double weatherstripped, double glazed, and has a smooth key locking device to prevent unauthorized persons from opening it, though it is readily accessible from both faces for washing from within the room.

A system of continuous baseboard heating elements is found running the entire length of the outside wall under the window, yet recessed so as not

to cause discomfort to a person sitting on the window stool seat. This is supplemented with a fresh air supply grille over the entrance to each room which can be tempered if additional heat is desired. The lavatory is placed in the room for greater flexibility, as well as a convenience to the doctors and nurses, thereby allowing both water closet and lavatory to be used simultaneously.

The requirement for free, open floor space as an aid in performing the many maintenance chores challenged the equipment planners. The result was that each patient would have only the following movable equipment: an adjustable height bed, one straight chair, one arm lounge chair, a combination diagnostic and floor lamp, and a bedside table containing a concealed tray for food service. The remainder of the usual requirements are found in the built-in closets, shelves and drawers.

Sloped interior walls create an intimate feeling in addition to breaking up sound reverberations. A complete wall of glass on the opposite side of the room creates a feeling of space. It was estimated that this type of window wall produced more than twice as much window area as is found in the conventional hospital. All of these features occupy less space per bed than the conventional two-bed ward does, and yet the area is above the minimum standard prescribed by the U. S. Public Health Service.

An interesting feature is the combination room signal light, door number, and commemorative plaque. In view of the difficulty of locating a room number on an open door, it was decided to combine these three elements into one, and place it on the corridor wall next to the door frame. A projecting plastic light with painted room numbers contains two bulbs, one for lighting the number, and the other, a colored lamp, serving as a nurse's signal light. It is relamped from the corridor side with the lower portion of the access door containing a riveted, aluminum etched inscription.

The floor patterns were developed later by putting these room elements together, and then by designing ancillary services which related specifically to each type of nursing unit.

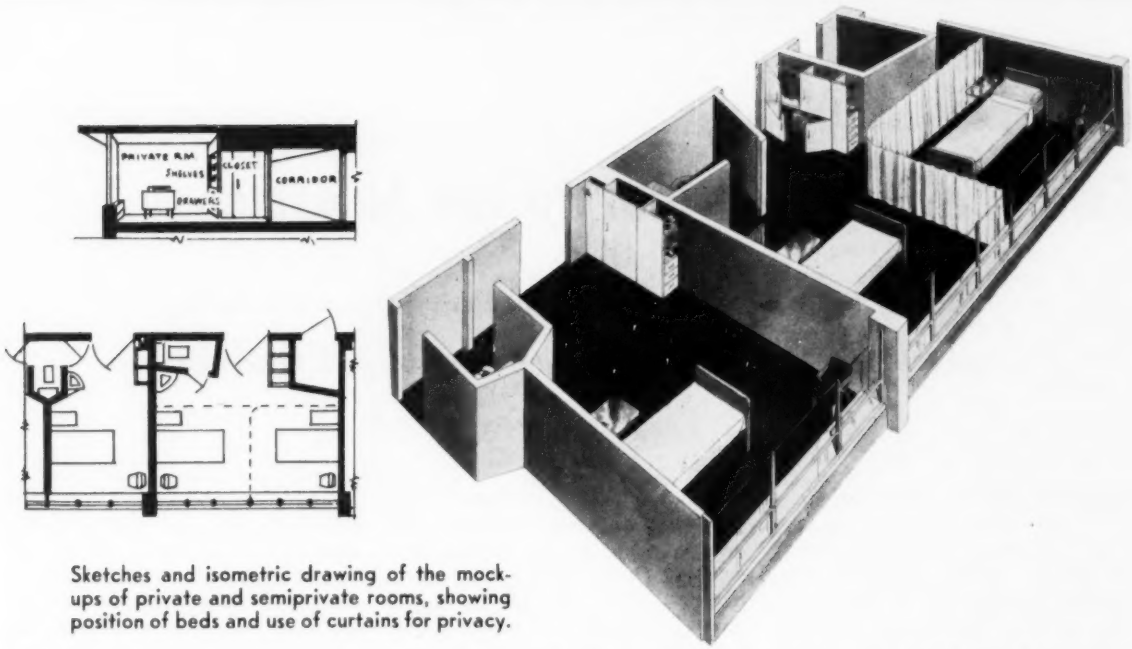
The plan followed in analyzing a typical bedroom floor was to set a pattern of three basic schemes, each embodying the principles of different locations for the service units with relationships to floors as well as departments: (1) located in the center of the east and west wings facing north, (2) using the double-corridor principle, and (3) a combination of these two schemes. Each of these was applied in conjunction with all of the various types of bedroom plans previously presented. The purpose was to compare the net and gross floor areas, the resultant width, the perimeter of building involved, and the number of beds in each. The solution presented in the final working drawings not only incorporated the best features of each plan but, as previously noted, also proved to be the most economical in space.

The heart of a nursing unit is the nurses' station; therefore, the "home base" for nurses in this plan is in the center and equidistant from each end of the corridor of each unit. The station contains a toilet, charting desk for nurses, stand-up desk for doctors, and a glass partition which extends into the corridor to give full view of the entire unit. Surrounding this "home base" are the segregated, yet combined and interrelated, clean and soiled utility rooms which contain the medicine preparation unit, with a glass panel for supervision of student nurses from the nurses' station; the treatment room, which doubles for doctor-nurse conferences; cart and chair storage, rubbish and linen chutes, bath, floor pantry, and main bedpan cleaning station. (Originally each room was designed to have private bedpan washing facilities in the private toilets.) The nurses' station will contain the latest type of two-way call systems.

The room compromise previously referred to is related to the percentage of private and semiprivate accommodations. Inasmuch as the newly developed semiprivate room in most respects embodies the features of a private room, the two are blended alternately with a proportion of about 63 per cent private rooms and 37 per cent semiprivate rooms, with subutility stations located along the corridor for convenience and efficiency. This provided a perfect orientation of north and south facing bedrooms, thus eliminating sun control devices for the east and west exposures which at best are only successful a small part of the time.

This desirable orientation produced a long strip building, and because it was not necessary to resort to the multistoried cross plan, usually designed for smaller sites, each individual wing is an entity within itself, except for the elevators and the least used floor service features, under the supervision of the floor secretary, located in the center core of each floor. This effected a saving in that each service element serves at least two and sometimes three 32 to 36 bed units. The distribution of single rooms at the extreme ends of the corridor will permit a flexible method of closing off any number of beds for isolation and communicable disease cases. A subutility post is located at the end of

Progress photograph of the construction of Rockford Memorial Hospital.



Sketches and isometric drawing of the mock-ups of private and semiprivate rooms, showing position of beds and use of curtains for privacy.

each stair tower to serve these isolation cases. The theory is that a patient who is hospitalized for more than one cause receives better care from the nurses handling that general type of medical or surgical case than he would in a separate isolation wing containing a composite group of patients. In other words, the classification places the communicable condition second, in most cases, to the other cause for hospitalization, if there is more than one. All units have been designed with this idea in mind.

The north wing contains the operating suite, the delivery suite and pediatrics department, units that generally require greater wing widths, less sun control, and the greatest amount of mechanical equipment all in stacked form.

A "T" shaped, four-story building resulted when all elements were accounted for, with each wing or unit being offset to avoid transmission of sounds and to increase efficiency of sight control. The first floor deviated from the "T" pattern established on the upper floors for obvious reasons. With this arrangement, however, came the age-old problem of having too many departments feed into a central core for vertical transportation. From about eight semifinal developments, the following plan was selected because of its efficiency, segregation and flexibility, which included provisions for future expansion of any and all departments contained on this floor without disruption of the interdepartmental relationship already established. Separate entrances for emergency, doctors, service deliveries, employes and visitors, and outpatients were incorporated, thus avoiding congestion and permitting good traffic control. Inasmuch as this floor is logically the noisiest, no bedrooms are located on it. From the main entrance, and large protected expanse of unloading platform, anyone may enter the hospital without climbing stairs, or even enduring a ramp.

The cafeteria to the rear of the administrative suite contains a small service unit for dispensing snacks, which will be operated by the women's auxiliary. The admitting suite contains a small x-ray unit which will become standard operating procedure for incoming patients. The outpatient waiting area is completely separate from the main waiting room, but has the same pleasant courtyard for a view. It has a separate reception station and control desk which governs all the pathological, radiological, physical therapy, and photographic departments in addition to controlling the emergency suite during those periods when a skeleton staff is on duty. The emergency unit has direct access to all the foregoing service units, in addition to a direct entrance into the operating suite. The corridor pattern permits inpatients to visit any of these departments, also, without disturbing the outpatient traffic flow, with complete privacy from view in the main waiting room. Future isotope and advanced radiology work, which requires greater building insulation, is planned as a separate wing to the rear of the radiology suite. This was done so as not to disturb the present department layout (which is probably one of the most expensive owing to the protective walls) and also because the needs and requirements for these advancements and facilities are still not definitive enough.

The first-aid rooms and examination rooms with a staff corridor running along the inner wall combine to form a flexible department for both activities simultaneously or the entire combined unit can be converted for one of the two purposes alone. The operating suite contains a 10 bed recovery suite, among many other features, which should prove to be invaluable not only as a recovery suite but also to double as an overflow emergency ward in case of catastrophes.

The basement elements flow as smoothly as the first floor of services, and exceptionally good natural daylight is afforded by warped grades, and sloped areaway retaining walls. Each group of nurses and employes has a separate locker room, showers and toilets. The laundry unit contains sewing, manufacture and reclamation services, and the morgue and necropsy unit is in an accessible yet segregated location.

Site planning, drives, parking, ultimate nursing school and residences, and medical arts building complete the over-all long-range plan for the medical center, with simple yet distinct drives and approaches to the various services and entrances defined by low guide walls.

The exterior sweeping horizontal planes and lines are expressed simply and complement the natural setting of the surrounding residential areas and countryside, yet en masse, the structure rises majestically upward to beckon and denote to all that this is a haven of rest and cure.

Said the Administrator to the Salesman:

"We're both working for the patient, and we'll both do a better job if we understand each other's problems"

WHAT does the hospital administrator expect of the hospital supplier? We expect courteous attention and prompt delivery of quality merchandise at a fair price. In one way, it is as simple as that—in other ways it is much more involved. I have talked with many administrators and this discussion is a summary of the points they make most frequently.

We expect salesmen to abide by our policies concerning the people on whom they may call. The fact that in a hospital 50 miles away they are permitted to call on every department head, to talk with the staff doctors in the hospital, to set up displays, and to hand out literature does not necessarily mean they can do the same thing in another hospital. Whether they agree or disagree with a hospital's policy, they should adhere to it. The administrator is responsible for his institution; he knows his community, his personnel and his medical staff much better than the salesmen do.

REMEMBER THEIR POLICIES

We expect salesmen to learn our policy on the first trip and to write it down some place where it can be referred to. We expect them to adopt our procedure concerning purchase orders. Where are they obtained? Are they numbered? If so, what is done with the number? Should it go on the invoice? Should it go on the packing slip? Should it be on the address label of the package? Does the purchase order state no substitutes? Does it say "no back orders"? If so, then that is what it means. Does it call for prices? If so, the price should be put down. Most purchase orders are tailor-made to fit a particular hospital and every word that is printed on them is there for a reason. Again, no two hospitals operate alike.

We expect salesmen to tell us the truth about delivery dates. If we order a piece of equipment that cannot be delivered for six months, we expect to be told it will be six months, and not that it will be four months, and from then on be told that the salesman can't understand why it hasn't been shipped; then that he has received the invoice and still later that he has the bill of lading and it must be tied up in a freight yard, when all the time he knows that the equipment has never left the factory.

We expect not to be overloaded at any time, and especially not when salesmen are leaving the territory. Occasionally, as a salesman leaves the territory he does overload a hospital, thinking he will pick up a little additional commission. The interesting part of this is that in many instances that salesman has gone on to a supervisory position in his company.

We expect suppliers to know their supplies, and by knowing them I do not mean knowing what is on the pink sheet that the sales manager prepared or on the colorful illustration sent by the manufacturer. We expect salesmen to know their equipment and supplies; we expect them to be able to teach our personnel how to use and operate them more efficiently; we expect them to be able to make minor repairs on that equipment. We realize that no general supply man can know the technical parts of all the equipment he sells, but we do believe he should be in a position to advise whether an article needs to be sent into the factory or whether it needs some minor adjustments.

We expect to be told the good points about the product, but we expect also to be permitted to find out the bad points about a competitor's product ourselves.

I have never sold anything. I don't know selling, but to the heads of hospital supply houses and particularly to their sales managers, I would like to direct this remark: "When you get a new item which you feel is particularly 'hot,' don't start a sales contest and don't ask your salesman to push that item until you have sold him on it." Don't expect him to sell a customer until he has been sold. To me there is nothing more pathetic, and pathetic is the only word for it, than a salesman who sits down across the desk from me attempting to sell me something, when I know that were he in my place he wouldn't buy it if it cost a nickel a carload. He doesn't believe in it and I can tell the minute he starts to talk that he is reciting so many words.

TELL THEM THE PRICE

The statement made oftenest by the administrators I have talked with was, "Why won't they tell us the price of things?" It seems that in many instances manufacturers keep their prices a top secret and to most administrators cost is a primary concern.

One administrator told this story, which I think is typical: There was an item of laboratory equipment in his hospital that was beginning to wear out. He knew he was going to have to buy a new one, in fact, he was going to replace two of them. He had checked back through the catalogs and had written down the manufacturer's number, complete description of the piece of equipment, including the voltage and various other pertinent information. Since this was an item that was "jobbed," he could buy it from any one of several supply men who called at his hospital. On two separate occasions, when he was busy and a general hospital supply man was in his institution, he sent his secretary out with all the pertinent information to ask one question: "What is the current price of this item?" Two salesmen refused to give the price to the secretary; they wanted to talk to the administrator. In this particular instance, the administrator probably knew more about the piece of equipment than did the salesmen,

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because it so happened that laboratory work had been his field before he became an administrator and was still his hobby. The catalogs he had were three or four years old and the only thing he wanted to know was "How much does it cost today?" He wanted to know whether he could buy it this month or whether he was going to have to wait six months before he could work it into his budget. He told me that he did buy two of them, but he wouldn't buy them from either of the men who had refused to give him the price. Good selling technic does require that the salesman first give the customer all the information concerning the product, and tell him how good it is and why he needs it; then, presumably, the price won't seem so high. But prices should not be such a deep secret.

We expect salesmen not to get "mad" when they are unable to see a purchasing agent or an administrator. Administrators are busy people, and the fact that a salesman has called three or four times and has been told that the administrator was out or out of town does not mean that a secretary is telling a lie. It means the administrator is active in association and civic work in addition to his hospital duties.

One administrator told this story, which I am sure happens seldom, but which in this case did happen. A salesman had called the third or fourth time at a particular hospital when the administrator was out. The last time he called, he made some cynical remarks to the secretary saying, "Just what do you have to do to get into that office?"

As the salesman left the hospital he apparently became angrier and angrier, because he wound up down the street in one of the local business houses and there proceeded to work into a rage and left the impression that perhaps the administrator was getting a rake-off from his competitor. Somehow he went from the local business house into the office of a member of the board of directors of the hospital, where he stated that he had an item which could save the hospital a lot of money, but that the administrator refused to see him. He suggested that the member of the board call the administrator and tell him to see the salesman. The board member, who was a successful banker and pretty wise in the ways of the world, said, "It has always been my understanding that part of the job of selling is getting in to see the customer." Most older salesmen know this, but inasmuch as we have been in a buying market for so long, I wonder whether all of the young salesmen realize that a part of the job of selling is getting in to see the customer. I am afraid there are some who not only expect the door to be open, but expect it to be held open while they walk through.

The problem of gifts to customers is a subject of genuine concern to state, regional and national hospital associations, as well as to the Hospital Industries Association. It seems to be growing and gathering momentum like a snowball and no one quite knows where it started or how to stop it.

Ethical hospital administrators and purchasing agents feel that if a gift has much more than advertising value it should not be accepted and, more important, it should not be offered. When an administrator or purchasing agent is offered a costly gift, he doesn't know what to do with it; he doesn't know whether to give it back or whether to accept it—and operate on the theory that an attempt is being made to influence his buying. He just doesn't know what to do. The salesman has created a problem for him, and it is never good to create a problem for a customer—he has enough of his own.

What about dinners? Suppliers have told me that a great deal of their expense budget is spent entertaining customers. My immediate reaction to that is, "It's your own fault." I doubt that any administrator or purchasing agent has ever asked a salesman to take him to dinner. Taking a customer to dinner should be purely social. It is a mistake to spend an hour, a half-hour or even 10 minutes in a purchasing agent's office talking about the football game, the election, or telling stories, and then take him out to dinner in an attempt to sell him a piece of equipment or a year's contract on some article of supply. Business should be kept in the office.

But salesmen may ask, "What about the administrators and purchasing agents who are our close friends? We play golf and poker together, our wives play bridge together; they have dinner at our house and we have dinner at their house, and last night we were all together drinking pink tea till 4 o'clock this morning and we had a wonderful time!" That friendship doesn't give a salesman the right to ignore the administrator's hospital policies the next morning, to walk past his secretary into his office and slap him on the back and say, "How's your head?" Friendship should be kept outside of the hospital.

Generally speaking, the hospital suppliers have a right to expect more of the administrator than we have a right to expect of them. We need a greater understanding of each other's problems. We need to begin calling each other by our right name. The salesman should know better than to say an administrator is "pigheaded," "stubborn," "conceited," when he means only that he is busy every time the salesman calls. I do not believe, either, that administrators should say a salesman is a "know-it-all," or "high pressure," when they simply mean he is trying to do a selling job.

It must be remembered that the hospital administrator and the purchasing agent are not spending their own money, they are the custodians of the patient's dollar and with that dollar they are attempting to buy him the very best in medical care. And I believe that every reputable hospital supply house is just as anxious to give the sick man the most for his hospital dollar—the hospital on a nonprofit basis, the supply house on a basis of reasonable profit. We are on the same team; we need to realize that neither of us can play the game alone.

Internship Is One Answer to the Nursing Problem

Internship gives the student nurse the opportunity for consecutive nursing practice under supervision, and also provides a constant supply of nursing service

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IN the fall of 1949, the instructional staff of Huron Road Hospital School of Nursing, East Cleveland, Ohio, undertook a complete revision of the curriculum and rotation patterns then in use. We were well aware of a twofold responsibility: Our first objective must be to provide a sound educational program, and, because this is a hospital school of nursing, our second objective must be to provide a portion of the nursing service for the hospital.

The school, at that time, had a nine months' preclinical term followed by a four-way rotation of students to the medical, surgical, obstetric and pediatric services. During the second half of the preclinical term, the students heard doctors' lectures in medicine, surgery and obstetrics. Nursing classes and clinics in these subjects were given concurrently with practice. Tuberculosis nursing, psychiatric nursing, public health nursing, and operating room experience were given in the third year. In the third year, we also included a three months' block of supervised practice in team leadership on the night, evening and day tours.

This kind of program obviously necessitates a great deal of repetition. The third-year students constantly raised the objection that they had no time to put into practice, under supervision, all they had learned. After several months of experimentation and consideration of the problems involved, the staff decided the answer was a rearrangement of the periods given over to classes, clinics and supervised practice so that there would be more continuity and consecutive study in each of these phases of the students' education.

Instructor demonstrating the heart to senior students.

The school affiliates with Western Reserve University for courses in anatomy and physiology, chemistry, microbiology, psychology and sociology; with the Cleveland City Hospital for two months of training in tuberculosis nursing and two months in psychiatric nursing; with Akron Children's Hospital for three months of training in pediatric nursing, and with the Cleveland Visiting Nurse Association for two months of public health nursing.

The plan that finally evolved may be described briefly as a two-year course in nursing, followed by one year of internship.

The first year is divided into two semesters and a summer session. The courses taken at Western Reserve University span the first two semesters. During the first semester, the student is introduced to the community and its resources by means of lectures and field trips. She learns to take care of herself, physically and mentally. The emphasis during this term is on the normal individual. The second semester is largely devoted to deviations from normal in an integrated program

Senior students demonstrating to ward class.

of medical and surgical nursing, nursing arts, pharmacology, diet therapy, public health, psychological aspects of disease, and pathology. The summer session is devoted to the medical and surgical specialties. Patient care is closely correlated with classwork, and all teaching is patient centered. Since the time allowed for patient care is restricted, every hour on the division must be a learning experience. These students do not contribute, except incidentally, to nursing service; they are constantly under the supervision of the instructional staff.

At the end of the first year, the student should be able to give safe care; she should be aware of the psychological and sociological aspects of disease, and she should be able to function as a member of a nursing team. We do not expect her to be able to perform nursing procedures perfectly.

TWO YEARS ARE UNINTERRUPTED

During the second year the student is introduced to the various specialties; at Cleveland City Hospital for two months of tuberculosis and two months of psychiatric nursing; at Akron Children's Hospital for three months of pediatric nursing; with the Cleveland Visiting Nurse Association for two months of public health nursing, and at Huron Road Hospital for obstetric nursing. These studies give the student a broad base for the nursing care of any patient.

At the end of the second year the student has received an uninterrupted and consecutive study of all of the basic requirements and is now prepared to put into practice, under supervision, all that she has learned.

We have designated the third year as an internship. During this year the student increases her skill; she learns to function as a leader of a nursing team; she is introduced to the responsibilities of the nurse during the evening and night tours; she completes her operating room experience, and she has an opportunity for practice on an elective service. Classes during this year are limited to four hours per week. The student, therefore, contributes 36 hours per week to nursing service. The internship affords the student the opportunity for consecutive nursing practice, under the supervision of the instructional staff, and at the same time fulfills the school's obligation to provide a constant supply of safe nursing service to the hospital.

During the internship year the student is permitted to live at home, in which case she is allowed a stipend in lieu of room and board provided by the hospital. This arrangement provides the student with some income and gives her a greater sense of responsibility. It further releases dormitory facilities, which will permit the school to enroll larger classes.

ENROLLMENTS HAVE INCREASED

The class admitted in September 1950 was the first to enter this program. It was with some fear and trepidation that we sent the students to their various affiliations in the fall of 1951. However, the students acquitted themselves well, and the affiliating agencies were pleased with their performance. In fact, the consensus has been that the members of this group are more eager to learn and more enthusiastic than is characteristic of the third-year student.

Much interest has been shown in the program since it was first announced, and applications for enrollment have increased considerably. Time only can tell what this program will accomplish, but from the results so far obtained we feel confident that it will help us find the answer to many of our problems in nurse education and nursing service.

In any evaluation of hospital efficiency,

both administrative and medical—

THE RECORDS TELL THE TALE

EVALUATION of medical and administrative function within the hospital is no easy task. For a long time medical and administrative divisions of the hospital staff have wrestled with this problem with varying degrees of success. Technics found useful in one institution may be entirely impractical to another. For example, professional service accounting as performed in the medical audit not infrequently requires more time and effort on the part of the auditing committee than most staff members are able to devote to it. When the medical audit has been completed, after considerable labor, one wonders whether the data obtained represent an adequate appraisal of medical competency, which is its primary objective.

The Massachusetts Department of Public Health is not primarily concerned with medical practice. Under the laws of the Commonwealth such matters are the responsibility of the Board of Registration in Medicine. Nevertheless, it is extremely difficult at times to separate hospital activities, which fall within the scope of the hospital licensing law, from medical care. In practice the line between these related functions becomes ill defined.

MEDICAL RECORDS

An appraisal of medical records has become an integral part of the state licensing procedure and is required by the regulations established under the hospital licensing law. While adequate records are necessary in order to meet hospital standards, we find, in most instances, excellent correlation between adequacy of records and medical competency. In the institution that provides adequate medical care, records are usually excellent. Physical examinations are performed and recorded promptly. Such items as progress notes, nurses' notes, special examinations, and procedures are carefully recorded, and the laboratory work is adequate for the particular disease. Orders for medication are signed by the physician and recorded in the order book. In this situation the hospital staff takes pride in its performance and the written record is a picture of the high quality of medical care.

Unfortunately, the reverse may be true. At times when medical records are inadequate, medical care may be poor. In some instances the pressure of a busy schedule may make it difficult for some physicians to keep records up to date. It is understandable that temporary lapses of this nature may occur. Occasionally, however, when poor records are the rule rather than the exception, it becomes the responsibility of the licensing agency to establish the cause and remedy the situation.

To demonstrate how an appraisal of records affords an excellent insight into the quality of medical care, I shall cite several examples.

Case 1: During the course of the routine survey to relicense hospital X, a 40 bed chronic disease hospital, certain inadequacies were revealed in hospital medical records. One such record dealt with the case of A. B., a 17 year old white girl, admitted with a diagnose of ulcerative colitis made at another institution. After a 15 day stay the patient died, and the primary diagnosis on the death certificate was circulatory collapse. Study of the medical record revealed, among other things, no admission physical examination, no progress notes, no adequate explanation for the discharge diagnosis, and no record of emergency measures instituted prior to death. The medication administered to the patient seemed unusual in view of the diagnosis of ulcerative colitis. Furthermore, examination of other records revealed that irrespective of the diagnosis, most patients received a similar form of therapy which consisted essentially of large amounts of fruit juices and colonic irrigations. Investigation of the hospital revealed several violations of our hospital standards, such as inadequate sterilization of instruments, poor x-ray department, faulty staff organization, inadequate personnel, and improper handling of drugs.

In view of these violations steps were instituted to deny renewal of the hospital license. Simultaneously, the previously mentioned peculiarities in the medical regimen prompted an investigation of the credentials of the chief of staff. Study of a photostatic copy of this physician's medical diploma, which was available in the records of the Board of Registration in Medicine, revealed a faulty Latin date, which directed our attention to several other inconsistencies in the material presented by this physician to the Board of Registration in Medicine. A translation of the Latin by a competent member of the staff of a near-by university showed that the Latin cardinals were incorrect. On the other hand, the Latin on a diploma presented by another graduate of the same year from this medical school was entirely correct. Upon questioning of the latter it was found that this physician did not recall the chief of staff as a member of the graduating class. This was confirmed by a class picture. Since the medical school was no longer in existence the physician's credentials could not be

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checked through this source. However, a deposition was obtained from the person who retained the records of the school stating that the physician in question had not attended the institution.

Examination of the questioned diploma further showed that the members of the faculty whose signature appeared on the diploma were not listed in the school's catalog for that year. Later it was found that one of the signatures belonged to a physician who had been deceased six years prior to the supposed date of graduation. At the hearing before the Public Health Council the application to renew the license of this hospital was denied and the institution closed its doors 30 days later.

The information gained as a result of this investigation was then turned over to the Board of Registration in Medicine for action with respect to question of improper registration. At the hearings conducted before the latter board it was established, as a result of chemical and microscopic analysis and by testimony of handwriting experts, that the diploma presented by the physician in question was actually a photostat and not an authentic diploma. It was also shown that for at least part of the time claimed to have been spent at medical school, he had been employed as a radio engineer in two different factories. As a result of the evidence presented before the Board of Registration in Medicine the physician's license to practice medicine in the commonwealth was revoked.

Case 2: This investigation was instigated by a complaint concerning the death of a child admitted to a licensed hospital for a tonsillectomy, the death occurring several hours after operation. Examination of the hospital record revealed several inadequacies. Laboratory data were not recorded and there was no report of a preoperative physical examination. There was nothing on the record to indicate that emergency treatment was instituted prior to death, and although the patient was taken to the operating room when postoperative bleeding was discovered, no mention was made of the findings or of the therapy.

It is a recognized fact that tonsillectomies may, in a small proportion of cases, lead to a fatality as a result of complications of one sort or another. However, it is important, particularly in severe cases of this type, that the record be completed with as much detail as possible. This serves a twofold purpose. In the first place, when the case is presented at the staff meeting it is more useful as a teaching medium, and, second, should questions of malpractice arise the physician's position is a more favorable one if the record has been adequately kept.

Case 3: During the inspection of a clinic licensed by the department a syringe partially filled with a bismuth preparation prompted study of the record of the patient receiving this medication. The patient had been admitted to the clinic with a diagnosis of syphilis, and over a period of two years he had received a weekly injection of a bismuth preparation. There was no record of a medical history or physical examination. There was only a single blood serology recorded, and this test was done when treatment was first started. There was no mention of lumbar puncture or spinal fluid findings. Furthermore, there was no evidence on the record as to the stage of the disease and whether it had been reported to the health authorities.

The absence of these items raised the question as to the medical competency of the clinic and examination of other records at the same clinic revealed similar inadequacies. Whereas the physician in charge of the clinic may have been able to explain some of these omissions, one wonders whether the professional service provided at this clinic was adequate. Although the department has no jurisdiction with respect to medical practice, it is apparent that close supervision of the medical records of this facility would obviously improve its professional services.

Case 4: During the course of a routine examination of a male patient by a physician in a chronic hospital, generalized edema was observed. In the absence of cardiac or nephritic disease or any other condition which might easily account for the edema, the examining physician instituted a careful study of this patient's record. The only clue as to the cause of the patient's edema was found in the nurses' notes where it was recorded that daily administration of fairly large doses of testosterone had been administered for a considerable period of time. It had been the intention to administer the drug for a shorter time. It had, however, not been discontinued by the physician. The edema promptly disappeared when the drug was stopped. Had the medication not been recorded in the nurses' notes it would have been impossible for the physician to have discovered the cause of the patient's difficulty. This case emphasizes the extreme importance of nurses' notes as a part of the medical record.

FINANCIAL RECORDS

Good financial records are becoming more and more significant in hospital administration. Many of the current financial problems have resulted from the wide variance in the accounting methods among hospitals. The lack of uniform statistical definitions, record keeping, cost distribution, and rate setting have brought considerable confusion in dealings with governmental agencies, Blue Cross and other third parties purchasing hospital care.

Administrators are constantly encountering greater problems in obtaining adequate remuneration for hospital services. Hospitals are becoming more dependent on agency payments and less on direct payments by patients. In many communities hospitals find that more than 60 per cent of their patients are covered by some type of prepayment plan. Governmental agencies, including industrial cases, cover another 15 to 20 per cent. This leaves a relatively small number of patients over whose rates the individual hospital has complete control. As contract or prepaid days increase, it becomes more important that the reimbursement method applicable to this type of care be established on a sound basis. A sound basis of third party reimbursement cannot be developed unless the cost of the services rendered is known. Often the cost is not easy to determine and some hospitals do not have complete and accurate figures. Accurate figures for a group of hospitals cannot be obtained unless all hospitals are speaking the same accounting language. The adoption of a uniform accounting cost distribution system, together with uniform statis-

tical definitions, is the only solution to this problem.

The hospital with sound accounting and statistical information concerning its own operations should be in a position to determine with a certain degree of accuracy the proper charges for its services. Many hospitals continue to adjust their income by increasing the charges for special services. Prices of special classes of professional service, such as x-ray and laboratory tests, are seldom based upon the total costs including allocated overhead of nonrevenue producing services. More important factors in rate setting among hospitals are:

1. The public's attitude toward prices for certain services.
2. The effect of a price change upon the utilization of the various services.
3. The total financial needs of the hospital and its revenue from other sources.
4. The differential costs involved in expanding or contracting the volume of certain professional services.

INCREASE RATES BEYOND NEED

While defending charges for radiology, laboratory work, and other combined services on the basis of going rates in the community, many hospitals have a tendency to increase these rates beyond the needs required for such a comparison. This has resulted in confusion in dealings with medical specialty groups when earnings from this source are compared with costs.

A review of the contractual arrangements of some 175 Massachusetts hospitals having contracts with Blue Cross indicated that 60 institutions were losing money because their charges for special services were less than cost. It is indeed a sad situation when roughly one-third of the hospitals in the state are losing money on services rendered to Blue Cross subscribers just because they are not in a position to determine the cost of certain hospital services.

This same confusion exists among many commercial insurance carriers. The American Hospital Association reported sometime ago that representatives of the insurance industry called to their attention the impossibility of writing insurance on an indemnity basis to cover hospital billings because of the wide variation of special service charges.

Now, there will always be some variance in the price of care among hospitals. Quality, utilization and general economic conditions directly influence these costs as is the case in any other business. As long as the rates have some relation to costs, hospitals are in a sound position to negotiate with third parties on the basis of billings, costs or a combination of both.

Composite costs of inclusive service are being used increasingly as the basis of reimbursement by contracting agencies. "Cost per patient day" is regaining stature as a measure of value and efficiency among hospitals. There are many factors which affect the cost per patient day incurred by a hospital during a given period of time. Some of these factors are:

1. Wage and price levels.
2. Amount and complexity of professional services.
3. Locality and design of the hospital plant.
4. Percentage of occupancy.
5. Degree of utilization of special services.
6. Definitions used for costs, for patients, and for days.

Last year the Massachusetts legislature amended the general laws relative to the supervision of Blue Cross in Massachusetts. The amendment provides in part that the commissioner of public health shall approve in advance all hospital contracts with Blue Cross and that the rates of payment shall be the equivalent of the actual cost to the hospital, or the charges to the general public, whichever is the lower.

Obviously, no approval based on this section of the law can be made without prior knowledge of each hospital's costs and charges in order to determine which is the lower. The determination of each hospital's costs and charges applicable to Blue Cross care has posed a tremendous task for the department of public health.

In order to determine each hospital's costs, it became necessary to develop a "Hospital Cost Statement." Such a statement, based entirely upon the latest accounting manual published by the American Hospital Association, has been prepared and approved by the Massachusetts Hospital Association. It has been designated in such a manner, together with the supporting cost analysis form, as to be adaptable to all third parties purchasing hospital care. From an administrative standpoint it was desirable to have hospitals standardize their accounting practices and submit a single set of forms rather than a variety of cost forms to the various agencies concerned. While the hospital statement of reimbursable cost does produce the necessary information for the purchase of all-inclusive care, it does not provide sufficient data for special types of care or partially indemnified care such as Blue Cross provides. In order to avoid a major transition on the part of the hospitals, it was our feeling that the task could be more easily accomplished in two parts. First, a uniform classification of expenses, and then a uniform cost analysis report. The first report will provide sufficient data for this year. It will be necessary to assume that one-third of the all-inclusive costs apply to ancillary services insofar as Blue Cross is concerned.

Inasmuch as the present Massachusetts Blue Cross contract provides for partial room and board coverage and full ancillary coverage, the problem is to determine the actual cost to each hospital for ancillary services such as x-ray, laboratory and drugs. There is no easy solution to this problem. In order to arrive at these costs, together with the costs of ward, semiprivate and private room care, a cost analysis form has been prepared.

TO DISTRIBUTE INCOME

The purpose of the cost analysis form is to segregate and distribute properly the various nonincome producing expenses over the income producing departments of a hospital. The proper completion of this form as a supplement to the reimbursable cost statement will enable the department to arrive at the actual cost of various ancillary services together with costs of ward, semiprivate and private room care. The actual cost of nursery care and outpatient clinic, private clinic, emergency and private referred services will be known. Uniform accounting practices among hospitals would provide operating figures for purposes of comparison. The inefficient operation of certain departments could be more readily detected.

It is apparent that record keeping is becoming increasingly significant as a measure of hospital efficiency. Medical records are an excellent indication of the quality of medical care, while uniform accounting methods will eventually provide a standard by means of which one hospital may be compared to a similar hospital with respect to cost of individual departments. It is expected that comparisons of this nature will help in pointing out deficiencies in administrative procedures.

Nursing Directors Could Write Better Reports

Study of the annual reports of nursing service in 100 hospitals in many cases reveals the omission of important information which would make for a better report and better nursing service

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THERE has been considerable interest in studying the various aspects of nursing service and in appraising the use of funds allocated to this area of hospital work. One of the ways in which the total nursing service program can be studied is through an analysis of the annual reports which the director submits to the hospital administrator. Because there is little in the literature to show the types of reports which are, or should be, made on an annual basis, a study was undertaken to determine the content and method of compiling such reports of hospital nursing services.

100 REPORTS STUDIED

Reports made in 100 general hospitals in the United States were included in the group studied and included those made in 12 hospitals operated under governmental and 88 hospitals under nongovernmental auspices. The institutions were located in many parts of the country and ranged in bed capacity from 250 to 3464, with the majority having from 250 to 450 beds.

Copies of the annual reports were not generally available for study because of the confidential nature of the information which they contained. However, sufficient information was submitted on a questionnaire to make possible an analysis of the content of such reports and to establish the ways in which they are written and presented.

Annual reports were made in each of the 100 hospitals by directors who held the titles of "director of the school of nursing and nursing service," "director of nursing service," "director of nurses," or "director of the school of nursing." The reports were written for presentation to the hospital administrator in 40 institutions and to the governing board in 12 institutions. In 43 hospitals the reports were submitted to both the administrator and the governing board, and in a few cases they were sent also to the state education department, the city council, the director of public welfare, and the state board of nurse examiners.

In analyzing the groups which contributed materials for the annual report it was found that the director wrote the entire report in 49 hospitals, while the director and the supervisors in the clinical nursing areas contributed in 21 hospitals. In 19 hospitals the annual report was a compilation of the separate reports of committee chairmen, clinical supervisors, and the director of the service. In five hospitals the director included reports made by committee chairmen and in three hospitals the annual report was a combination of reports submitted by the nurse supervisors in the clinical areas.

The reports were written in descriptive form, with 59 directors indicating that they included statistical data and 11 using charts and diagrams as aids in presenting the materials.

The specific types of information included were classified under the headings "Activities" and "Personnel" and the total number of directors who indicated on the questionnaire that information was always or sometimes submitted in the annual report is shown in Table 1.

Most of the directors included information about nursing service activities although there was variation in the type of information reported by them. More than half of the directors tended to report the number of hours of service rendered and to discuss the major activities engaged in by nursing service personnel during the year for which the report was being made. Somewhat less than half of the directors discussed the accidents and hazards encountered in rendering the service.

ANALYZE NURSING ACTIVITIES

It seems important to give some attention to the activities now being performed by nursing service personnel. The tremendous cost of this service and the lack of sufficient numbers of qualified workers would make analyses of this phase of the work worth while. The many diverse groups of people to whom nursing personnel renders service and the need to determine with great accuracy the amount of service nurses render for such other departments as the dietary, pharmacy, laundry and linen supply, clinical laboratory, central supply room, and other departments exists in almost all hospitals and this, too, emphasizes the importance of including a summary of the activities.

In an analysis of the data reported under the classification of "Personnel," it was found that the directors tended

Table 1—Information Relating to Nursing Service Activities and Personnel Included in the Annual Reports of Directors of Nursing in 100 General Hospitals

Type of Information Included	Number of Directors Reporting Information		Total Number of Directors Reporting
	Always Included	Sometimes Included	
Activities			
Number of hours of service rendered	57	11	68
Major types of activities performed	43	18	61
Accidents and hazards encountered	18	17	35
Personnel			
Number and types employed	84	6	90
Employment of new staff	75	10	85
Promotions	68	13	81
Termination of employment	60	13	73
Turnover rates	51	14	65
Personnel problems	47	15	62
Leaves of absence	46	10	56
Transfers	45	15	60

to report the number and types of workers employed, the employment of new staff members, and promotions oftener than they reported other types of data. The apparent lack of interest in including such information as turnover rates and personnel problems seems to point to an inadequate understanding of the use of these data or to a reluctance to discuss difficulties which may have arisen in administering the service during the year.

REPORT ON NURSES' HEALTH

The health of employes has a direct relationship to their efficiency and may affect, directly or indirectly, the cost of the service rendered. In an agency which itself is engaged in rendering health service the health of its employes should be a matter of particular concern, but the replies on the questionnaire indicated that less than half of the directors included information about the health of the nursing service staff and health services rendered to this group.

A total of 57 directors reported information about orientation programs and 73 reported on-the-job training programs. Eighty directors discussed the in-service education programs which were conducted for the nursing service staff.

The exceedingly important subject of research in nursing was made a part of the annual report by 55 directors and public and professional relations activities were included by 63 directors.

Replies from 90 directors indicated that the number of professional nursing students in their schools ranged from 40 to 350 students, with 130 students in the median school. Twenty-five hospitals had practical nursing students and the size of their groups ranged from two to 250 students, with 60 students in the median institution. A total of 44 directors reported on the work of the nursing service staff with the faculty of the school and their reports were mainly on the joint activities of the two groups. There did not seem to be any correlation between the size of the student body and the tendency of the directors either to include or to omit this type of information from their annual reports.

While the budget would be submitted in accordance with the policy of each hospital, it was found that a total of 20 directors included information relating to the nursing service budget in the annual reports of the service.

On the basis of the recommendations made by the national professional organizations for the factors to be considered in administering a sound nursing service program, and on the basis also of the suggestions contained in authorative literature in the field of business administration and public relations, it is concluded that the following types of information might be included in a comprehensive annual report of nursing service in a hospital:

1. Statement of the aims or purposes of the nursing service program.
2. Organizational and administrative changes and problems.
3. Data on facilities, equipment and supplies of importance in rendering the service.
4. Nursing service personnel (number and types of workers employed, new staff members, promotions, transfers, termination of employment, leaves of absence, turnover rates and problems).
5. Health of personnel and health services rendered (number and types of examinations, amount and types of illness, accidents and injuries).
6. Activities included in the nursing service program (number of hours of service rendered, major types of activities performed, accidents and hazards encountered).
7. Special educational programs conducted for and by nursing service personnel.
8. Nursing service budget. (If the budget has been presented separately, a statement of the relationship of the budget to the accomplishments of the service might be included in the annual report.)
9. Research in nursing services (purposes of studies made, results and recommendations).
10. Activities carried on to further professional and public relations.
11. Work of the nursing service staff with the faculty of the school of nursing.

REASONS SHOULD BE STATED

Whatever recommendations are made in the annual report concerning any phase of the nursing service program should be made in specific terms with a clear statement of the reasons for presenting the recommendations. Where the nursing service staff has suggestions to make about ways in which its recommendations might be achieved, such suggestions—and the reasons for making them—should be included.

The work that individual nurses do to build an adequate and concise report of the service rendered during the year that has passed and their plans for the year and years ahead should do a great deal toward making them cost conscious. It should help also in promoting their understanding of their work and full responsibility in the hospital world.

A review of the place and function of

Depreciation in Hospital Accounting

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THE intent of this paper is (1) to review the place and function of accounting for and reporting depreciation on plant assets in public and endowed hospitals (as distinct from proprietary) and (2) to question the methods for such accounting proposed by a committee of the American Hospital Association.[1]

It is well first to inquire as to the purpose of depreciation accounting in general. This is clearly covered in numerous references. The definition of depreciation by the American Institute of Accountants is: "Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the tangible unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation."[2]

Others describe depreciation as "the setting up of the charge to operation . . . as a result of which dividends are restricted to true net earnings and capital impairment is avoided."[3]

According to these statements the purpose of depreciation accounting in private business is to distribute the cost of the assets over their useful life, toward the end of arriving at a more nearly accurate net profit, *especially for the purpose of restricting the amount of dividends*. These needs are not present in institutions which do not operate for profit. Even though a profit were made, it would not be distributable as dividends. Hospitals are generally of such a character.

The difference between the objectives and procedures of commercial enterprises in which depreciation is properly included as an element of cost should be recognized. The purpose of a commercial enterprise is to produce income. Therefore, depreciation is applied to fixed assets properly to compute the income produced, and to allocate to income all costs of producing it. There is a direct relation between income and the fixed assets used to produce that income. In social enterprises, on the other hand, the purpose is to serve the community, not to produce income. There is, therefore, no such direct relationship.

IT'S A JOINT ENTERPRISE

A commercial enterprise must pay *all* of its *costs* from income of its activities. This is not true of a social enterprise. Support of the latter in this country is a "joint venture." The patient (in the case of a hospital) bears part of the cost through direct payment; the people bear part through their government by making appropriations for capital costs and by exempting the enterprise from direct taxes on income, property, and gifts received; and society as a whole bears part through direct gifts. Past generations contribute to present support through endowment funds, while the present generation supports the enterprise through gifts of money and gifts in kind.

Since by the definitions cited depreciation represents the recovery of an expenditure, and since expenditures for plant assets usually are not made by governmental or other nonprofit agencies out of funds contributed by them, but out of funds appropriated to or given them by others who are not concerned about recovery, the problem and treatment of depreciation in such enterprises are different from those in privately owned and profit seeking enterprises generally. As it is not the purpose or intent of hospitals to yield a profit, a device used for profit computation, the customary depreciation charge, seems out of place in this type of organization.

It is sometimes said that depreciation should be shown to indicate that the original investment is worth less and less. This fact is not brought out by depreciation accounting, as depreciation has nothing to do with current valuation of properties. Furthermore, the question as to what extent wear and tear and obsolescence have been met by new expenditures is involved. There is no such thing as an actual life of such properties that can be reduced to bookkeeping figures such as is implied by the use of depreciation entries.

It is worth while to observe the position taken by other groups that have studied and developed standards of accounting for various nonprofit enterprises. The National Committee on Governmental Accounting has this to say about depreciation in governmentally controlled activities:

"Depreciation on general municipal fixed assets should not be computed unless cash for replacements can legally be set aside. . . . Governmental bodies do not operate for profit, and even though a profit is made, it is not distributable as dividends. General fixed assets are not presumed to produce revenues, and to charge current operations with depreciation has the

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[1] Section I, Uniform Hospital Statistics and Classification of Accounts. Chicago, American Hospital Association, 1950.

[2] Accounting Research Bulletin, No. 22, May 1944, p. 179.

[3] Paton, W. A.: Accountants Handbook. New York: Roland Press Company, 1949, p. 747.

effect of producing revenues by costs to which they do not give rise."[4]

Another national committee dealing with educational institutions has stated its stand as follows:

"Since in general the property used specifically for the educational function of the institution was initially provided by gifts, grants or legislative appropriations, and since such property is usually replaced in like manner, it is not necessary to accumulate funds for renewals or replacements out of current income.

"If replacement funds are created for institutional property or if charges for depreciation are entered as current expense, they should be represented by cash or liquid assets included in the plant funds group."[5]

The committee of the American Hospital Association has apparently departed from these recommendations and interpretations of depreciation in social enterprises. In its most recent handbook (1950) the committee states: "Depreciation of hospital buildings and equipment should be recognized as an element of hospital expense. The depreciation in value of buildings and equipment represents a real cost of hospital service, even though such assets may have been contributed originally to the hospital, and even though no cash or other funds are set aside to replace such assets."[6]

The purpose of depreciation is defined in the handbook as:

". . . the gradual absorption as expense of the cost of buildings and equipment to reflect the effect of wear and tear, inadequacy, obsolescence, etc."[7]

The committee thus seems to emphasize wear and tear and amortization of investment, as contrasted to the emphasis by leading accounting authorities on depreciation's being the recovery of costs. Inasmuch as the institution itself has not provided the investment in facilities, the latter does not represent a cost to it and does not require recovery through depreciation charges against current income. As to obsolescence and wear and tear, if provision for these items is to be made through charges against income, then the accounting must be of such a nature that funds are not only secured through income but are reserved for that purpose, as will be indicated in later discussion.

The committee's recommendation also seems to be a recognition of the value basis for such charges. However, the authorities cited agree that depreciation is not recognition of a decrease in *value*, but is an annual allocation of *cost*. The purpose of charging depreciation is to spread the cost of fixed assets against the income which they help to produce. Hospital buildings, as a rule, are erected from funds furnished by the community, from philanthropic sources, and, frequently, governmental contributions. Assets acquired in these ways are not, therefore, subject to depreciation charges, when viewed in this light.

The committee in its handbook[8] recommends the following entries relating to depreciation (figures taken from a hospital problem in November 1951 C.P.A. examination of the American Institute of Accountants[9] are added to emphasize the effect of these entries):

1. Entry to record depreciation:

General Fund: Dr. Provision for Depreciation	**$29,848**
Plant Fund: Cr. Reserve for Depreciation	**$29,848**

Taking this entry by itself it is obvious that it violates a fundamental principle of fund accounting in that a debit entry is made in one fund group and a credit entry in another. In an apparent effort to correct this situation, the committee then proposes the following:

2. Entry to maintain the self-balancing feature of each fund group:

Plant Fund: Dr. Capital—Invested in Plant	**$29,848**
General Fund: Cr. General Fund Balance	**$29,848**

The net effect of these entries is to offset and eliminate the depreciation expense charge in the general fund as far as the final effect on surplus (general fund balance) is concerned. It is true that any entry for depreciation reduces the amount of "net income" (or increases "net loss") for the year, but since the general fund surplus is immediately again credited with the amount charged for depreciation, it stands at the end of the year without reduction for this depreciation.

In some instances, further confusion is created by describing the so-called transfer from plant fund to general fund as a "Contribution to Expenses From Plant Fund." There is, of course, no "contribution" from plant fund because that fund has no cash and no cash is transferred. There is, in fact, no "reserve" for depreciation set up opposite the "expense" for depreciation, in the customary manner of depreciation accounting, because the "reserve" is in a different fund than the fund in which the expense entry is made.

The futility of such a set of entries should be evident on their face. Not only are fundamental principles of fund accounting procedures violated but the net result of the procedure is zero. The depreciation expense account has been charged and later closed to general fund balance account so the effect of the depreciation entry is nullified. Furthermore, the fundamental principles in the intent of depreciation accounting are violated: Depreciation is entered as a cost when no cost has been incurred; the entry in plant fund suggests that depreciation has been recovered out of income and that in fact is not the case.

Some writers[10] argue for inclusion of depreciation (both equipment and buildings) as an item of cost in operating statements on the grounds that: (1) The cost of producing hospital service is not correctly stated unless depreciation is considered as an element of cost, (2) operating statements and cost summaries prepared for management and trustees would be more informative if building depreciation were worked into the figures as an operating expense, (3) there cannot be a true comparison of results as between hospitals or a test of the efficiency of hospital management if so important an element of cost as depreciation is omitted from accounts and reports. These ends are justified primarily from the point of a commercial operation. Each of them contains serious fallacies and impracticabilities from the standpoint of a nonprofit operation, as has already been indicated. On the point of "comparison," in no way could the item of de-

[4]National Committee on Governmental Accounting: Municipal Accounting and Auditing. Chicago, 1951.

[5]The National Committee on the Preparation of a Manual for College and University Business Administration, Vol. I, Chapter II, American Council on Education, Washington, D.C., 1952.

[6]Ibid: p. 106.

[7]Ibid: p. 65.

[8]Ibid. Section 1.

[9]Journal of Accountancy, February 1952, p. 248; Accounting Review, April 1952, p. 254.

[10]Staub, Walter A.: Replacement Policy for Depreciation in Hospital Accounting, Journal of Accountancy, May 1941.

preciation be really useful in this respect because it is based on a wide variety of original costs and conditions, and is not subject to management control.

The confusion of treating depreciation accounting as an adjustment in values is well indicated in a work by Roswell.[11] His general outline of treatment of depreciation accounting is similar to that of the committee. However, he says: "Over a given period capital assets such as buildings and equipment decrease in value by reason of usage, obsolescence, accidents, elements, or other causes, therefore, *in order to avoid an overstatement of asset values* it is necessary to provide for a 'reserve for depreciation.'" (Emphasis added.)

Martin[12] commits the same error of stressing "decline in the value of the fixed assets" as a reason for recording depreciation, but is more logical as to the use of depreciation charges in relation to replacement. "Since the cost of replacement of hospital property must be met by the general fund, it is important that revenue from all sources be maintained in an amount equal to the operating costs, including depreciation." However, he then outlines entries which are as dubious as those of the handbook: Depreciation is charged as an expense with immediate corresponding credit to general fund surplus. Thus his stated objective is nullified.

Mikesell[13] presents entries similar to those indicated by the A.H.A. committee. He then adds the following meritorious proposal:

"To assure the availability of money for replacing assets retired, the recording of depreciation may be followed by a cash transfer, for which entries in the following form might be made:

Plant Improvement and Replacement Fund
Assets (Plant Fund)
Cash (General Fund)
General Fund Balance (General Fund)

Reserve for Plant Improvements and Replacement (Plant Fund)"

In an effort to get some check on present practice, an analysis was made of the financial reports of 180 different hospitals, including 41 public and 139 endowed, issued in the three years ended in 1951 and on file in the A.H.A. library in Chicago.[14] In 53 per cent of public hospitals and 39 per cent of endowed hospitals, there was no evidence of any treatment of depreciation on equipment. In the same per cent of public and 44 per cent of endowed, there was no evidence of the entry of depreciation on buildings. An additional 9 per cent showed a depreciation reserve in statements, but the way it was set up could not be determined. Practically all those showing depreciation treated it as an expense, but only about 5 per cent had funds reserved for replacement.

The reports were incomplete in many respects; for example, 94 per cent showed no separate surplus statement, hence it was impossible to determine the exact method of treating depreciation. Other inadequacies were evident; for example, 42 per cent of public and 13 per cent of endowed hospitals had no balance sheet. Also, 42 per cent of public and 28 per cent of endowed hospitals which did have balance sheets showed no fund segregation. *Only 21 per cent of all reports showed the form of balance sheet recommended by the A.H.A. committee.*

Obviously from this review there is considerable interest in the question of depreciation and a substantial number of hospitals are making an effort to consider it. How well the item is treated from an accounting standpoint cannot be definitely determined, but it is reasonable to assume the treatment is incomplete in very many instances.

It was interesting to note that accountants' certificates, indicating compliance with "generally accepted accounting principles," were given to hospitals which charge depreciation in any manner, and also to those which did not charge it at all. One certificate of a well known national firm on the report of a large endowed hospital reads as follows:

"In accordance with common institutional practice, no depreciation is provided on the hospital's buildings and equipment except for amounts annually appropriated to the reserve for replacement of equipment." At least this firm believes this to be the most usual practice.

In recent years considerable emphasis has been added to unit cost accounting in hospitals as a necessary basis for obtaining proper compensation under various hospitalization insurance plans, or from government agencies making compensation to hospitals for services to their beneficiaries. Generally speaking, insurance companies and associations, as well as govenment departments, recognize depreciation as an allowable item of cost in arriving at rates, and some require its inclusion in reporting costs. Few, if any, however, actually pay benefits at a rate which covers even current costs, let alone depreciation. Even if depreciation is allowable and is needed as an element for rate making, this does not justify the method of accounting proposed in the handbook. To have it "put in" and "taken out" in the manner that is recommended in the handbook might easily lead persons concerned in checking rates to conclude that actually it had *not* been included in costs.

In this discussion the effort has been made to establish that: (1) depreciation accounting along customary commercial lines is not appropriate for nonprofit hospitals because (a) the functions of such accounting are to distribute costs over useful life and recovery of expenditures, particularly for the purpose of restricting the amount of dividends, and (b) since costs have not been provided by those who own and operate the hospitals, it is not appropriate that they be included in the accounts; (2) depreciation has no relation to current values and current values have no significance in nonprofit institutions, hence, any attempt to reduce the book value by amount of depreciation is fruitless and meaningless, and (3) depreciation has a usefulness for rate making, but the procedures recommended by the committee are not such as to provide a consistent and logical accounting of it as an element of cost.

There is another relationship, however, in which depreciation is important where a charge against the current income in relation to the property used is important; that is in connection with replacement. The mere bookkeeping process of depreciation does not result in the accumulation of funds for replacement. This is not accomplished unless funds are actually reserved for that purpose.

These facts appear to have had only passing consideration by the committee and by other writers, yet they are fundamental in their nature. Hospital facilities do require not only maintenance but eventual replacement. A

(*Continued on Page* 136)

[11]Roswell, Charles G.: Accounting Statistics and Business Office Procedures for Hospitals, United Hospital Fund of New York, 1946.

[12]Martin, T. Leroy: Hospital Accounting, Principles and Practice. Chicago: Physicians' Record Co., 1951.

[13]Mikesell, R. M.: Governmental Accounting. Chicago: Richard D. Irwin, Inc., 1951.

[14]Study made by Leon E. Hay, C.P.A., and Bablyl S. Hay, C.P.A.

Modernization Was Costly — But Worth It

New laboratory helps fulfill hospital's objective of service

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Administrator, St. Joseph's Hospital, Elmira, N.Y.

BECAUSE the reconversion and modernization of the clinical pathological department of St. Joseph's Hospital, Elmira, N.Y., presented complications ordinarily not encountered in designing new buildings, our project demanded great accuracy in planning and great care in purchasing. The successful completion of these plans was effected by the collaboration of hospital officials with the architect, pathologists, physicians, science professors, technologists, the engineer, hospital and local mechanics, and specialized equipment manufacturers.

A primary factor that must be considered in the location of a laboratory is accessibility. Obviously, in a new construction, the first floor laboratory placement is ideal. However, in our reconversion project this was not possible. The fifth floor of our hospital was originally designed for special service units, although in addition to these it had one nursing unit. During the passage of years, as the need arose, one room after another was taken from the patient area and assigned to the services of pathology, radiology and deep therapy. To reopen the remaining rooms for nursing service seemed unwise, and, from an administrative and economic point of view, unsound. Only after much study of the alternate sketches prepared by the architectural firm of Haskell, Considine and Haskell was this nursing unit rebuilt to form our present laboratory. The laboratory's proximity to our x-ray and deep therapy units and the elevator service from the ground to the fifth floor assure ready access from other hospital areas with minimal confusion for hospital employes, patients and outpatients. Then, too, this new laboratory occupies a wing horizontally contiguous to the majority of the clinical divisions in the hospital which it is designed to serve.

An available tentative yardstick furnishes a useful basis for quickly estimating laboratory area requirements. But, however accurate a measure of laboratory capacity this may be, the immediate requirements of the situation in question will call for some variation. The U.S. Public Health sets up the following area distribution chart for a 200 bed hospital: pathology laboratory, 745 square feet; BMR and EKG and specimen room, 207 square feet; office, 170 square feet, and morgue, 495 square feet, a total of 1617 square feet.

After thoughtful consideration of the normal requirements of the hospital's routine day, we allocated 3800 square feet and 16.7 square feet per bed for current needs and 600 square feet as a reasonable provision for future expansion.

The total expense has been minimized by the time and effort spent in careful planning before the construction period began. Then, too, the new facilities are adapted to economical operation. The money invested in the laboratory purchases so far is yielding the return of the full dollar value. This is partly because supply companies offer standard-unit construction, the purchase of which assures far-reaching economy.

DESIRABLE PHYSICAL FEATURES

Our total expenditures, excluding the salaries of hospital maintenance employes who hung the wall cabinets, built the fume hood, and installed the standardized units, amounted to $30,-720.07. This sum includes furnishings and movable equipment.

The following desirable physical features appear in our plan:

Cabinet work 36 inches high of light-colored oak with acid resistant hardware.

Working surfaces 30 inches high (with curbing wherever practicable) impervious to acids, alkalies and solvents.

Recessed base moldings and leg sockets of chemically resistant synthetic rubber.

Numerous conveniently placed chrome-plated electric, gas, steam and plumbing fixtures.

Adequate sinks with cabinet bases.

Wall cabinets 12 inches rather than the standard 15 inches above table tops.

Knee hole provisions enabling two technologists (student and registered) to work side by side.

Stools automatically adjustable, with rod base covered with 1 inch black rubber tubing.

Architectural projected steel sash windows 4 feet by 6 feet 6 inches.

Four-tube fluorescent ceiling fixtures.

Laboratory unit side walls painted pale green or light gray above 68 inch light-reflecting glazed tiled wainscot.

Many factors enter into laboratory construction. Significant among these in our hospital are the following:

Location. The new laboratory unit faces north but benefits from east and west exposure.

Structure. The medical wing which houses our new laboratory facilities is a steel frame structure with exterior walls of masonry, concrete floor slabs, plastered gypsum partitions, wood doors hung in steel bucks, and suspended ceilings of metal lath and plaster.

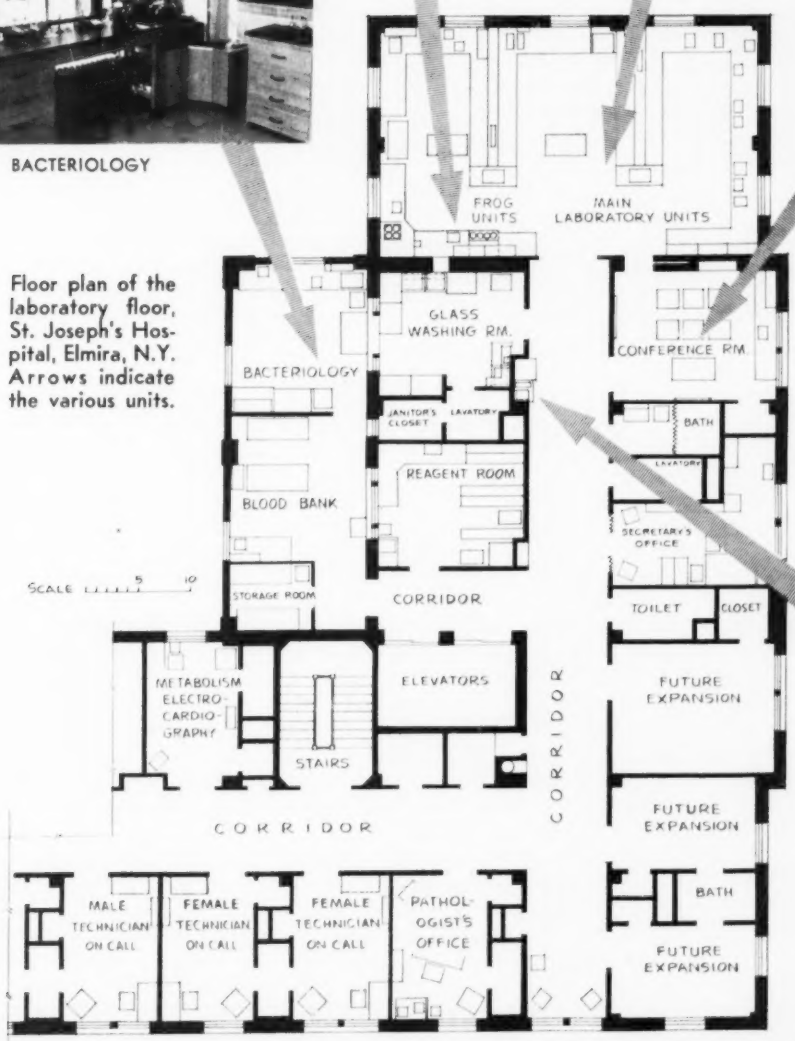
Electric power. The initial and antic-

FROG AQUARIUM

MAIN LABORATORY

BACTERIOLOGY

CONFERENCE ROOM



Floor plan of the laboratory floor, St. Joseph's Hospital, Elmira, N.Y. Arrows indicate the various units.

FLOOR SUPPLY CABINET

ipated electric power needs are adequately supplied.

Floor covering. A gray rubber floor covering is used in the entire unit except for asphalt tiling in the glass washing unit, vinyl plastic tiling in the blood bank and bacteriology units, and terrazzo flooring in the morgue and necropsy room.

Heating. Heating is produced by direct radiation from radiators hung under the windows.

Plumbing. The copper water piping, accessible through panels, is concealed above suspended ceilings. Sink plugs, strainers and traps are of chemical lead except where acid-resistant iron ones are needed. Drain lines in pipe shafts with a panel door are of heavy cast iron.

Ceilings. Acoustical tile, 12 by 12 by ¾ inches, effects approximately a 65 per cent noise reduction.

Walls. Pale green, soft rose, and pale gray ceramic tiling protects the plastered side walls to a height of 68 inches in the main laboratory, the conference room, the bacteriology room, and the blood bank room.

Communication. An intercommunication system transmits messages readily and audibly from the secretary's office to each laboratory worker. Telephone jacks permit the removal of the phone from the secretarial area to the unit where the "on call" technologist is working.

Main laboratory room. Here technologists work in biochemistry, hematology, serology and histology. For their benefit innovations were made.

Of special value in the urinalysis area is a window opening into the glass washing room, which permits ready transfer of glassware.

Carefully constructed by the hospital carpenter, our table-model fume hood now utilizes a corner space. The workmanship and finish equal normal commercial standards. Incorporated in it are such details as vapor light, moisture-resistant walls, motorized exhaust, steam-water bath, gas and water fixtures.

Chrome-plated water piping and mechanical service outlets placed in the reagent rack better serve the needs of the technologists. Two specially designed burette holders placed directly on top of the reagent racks to raise the solution bottles to proper height were constructed by the hospital maintenance men.

In close proximity to the hematology area, a bridge-like slide holder installed in the sink allows the staining of slides and eliminates the customary untidiness.

A small carbon tetrachloride fire extinguisher is attached to the wall.

Glass washing room. Here are adequate sinks, sufficient working space, ample storage cabinets, and a separate area for the acid cleaning of glassware. A recessed steam-warming cabinet, which is invaluable, dries trays of wet glassware quickly and spotlessly. A technicon washer on a shelf adjacent to a low, flush type of sink permits a rapid, thorough rinsing of pipettes. A distilled water container next to a wall-mounted reflux still (10 gallons per hour) is in a hanger directly over the sink, conveniently placed for the ready flushing of glassware.

Reagent room. Designed by our chief technologist, this room is proving practical in several ways. Here stock chemicals, alphabetically arranged on open steel shelving, can be readily noted and stored. Duplication of these supplies is thus eliminated, and there is better utilization of the consequent available cabinet space in the other laboratory rooms. Now all solutions are being made in the reagent room. The table tops elsewhere can be used for other purposes. The accuracy of the sensitive balance remains unimpaired since this room is away from all vibrating apparatus.

Conference room. Classes, lectures, research and medical photography work into the program of the conference room. Excellent colored transparencies of macroscopic and microscopic specimens provide pertinent and informative subject matter for lectures. A hospital-made standard with telescoping sides and a low base covered with dark linoleum and flawless glass makes photographing of specimens easier.

Outpatient room. What was formerly a shower and tub room is now the outpatient unit. The shower and tub are retained, but this section is partitioned by an accordion folding door. Though the remainder of the room is small, it has all the equipment necessary, such as good lighting, table, chair, clothes hanger, and supplies. Also, there is privacy here when the technologist obtains blood specimens from outpatients.

Floor supply unit. For efficient service in a new construction, the ideal situation calls for laboratory supplies in close relation with the dumb-waiter service. For practical purposes in our laboratory, a cabinet for supplies, requisitions and specimens is located in a recessed corridor area. Carefully labeled boxes save time and prevent possible errors.

Bacteriology unit, blood bank, storage room. Partitioned areas on what was formerly a porch now house the bacteriology unit, blood bank and storage room. Natural lighting in this area was carefully provided by the installation of glass block. One architectural projected window is in each room. The most remote room is for bacteriological tests. The same structural convenience for slide staining is used here as in the hematology unit. The motor for the anaerobic culture apparatus is concealed below the sink. The 18 inch shelf to the right provides the necessary working surface. Soiled glassware is readily transferred to the glass washing room through a pass window.

Adjacent to the bacteriology division is the blood bank room. For emergency use one donor table is available. Since our hospital participates in the Rochester Regional Blood Center Program, the bleeding of donors here is infrequent. The intercommunication system between this room and the hematology unit permits a rapid exchange of reports.

Open shelving lines the two walls in this storage room. On one side below the shelves bulky items rest on home-made dollies. Placed in one corner is the motor for the blood bank refrigerator with revolving shelves.

Secretary's office. An accordion folding door provides privacy for the secretarial area. On the large desk the master intercommunication station, private and house phones rest within easy reach. Shelving for records and readily accessible slide filing cabinets are useful time and effort saving equipment.

Pathologist's office. On a table directly behind an executive desk trays of slides, a microscope, a lamp, and a dictaphone are available.

Locker room. Two rooms assigned to male and female technologists respectively serve the dual purpose of lounge and locker areas and sleeping rooms for "on call" technologists.

Basal metabolism, electrocardiography, gastric analysis. A separate room in a quiet location, a little removed from the main laboratory unit, is used for basal metabolism rate tests, gastric analyses, and electrocardiograms. To conserve space, a chaise longue is used as a bed here.

How Does Your Nursery Rate?

Part 1 of a survey of hospital practices in regard to care of the newborn

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IN 1951 I made a survey of hospital practices in regard to the care of newborn babies, the results of which were compared with the standards set by the American Academy of Pediatrics[1] for the care of the newborn babies, and also with the current literature.

Five hospitals were visited and 13 questionnaires were mailed to other midwestern hospitals. The results of information gathered were so interesting that questionnaires were sent to all hospitals connected with medical schools which had a bassinet capacity of 45 or more. These hospitals were approved by the American Medical Association. In all, 98 questionnaires were sent (counting the original 13 mailed plus the five hospitals visited). Eighty-three questionnaires were returned. Of the 83 hospitals, 81 were listed in *Hospitals* for June 1950 as being connected with medical schools. This listing did not specify whether the medical schools used the hospitals for obstetrics, but simply that the hospital was connected with a medical school.

The survey was completed in August 1951. For the purpose of this article, the data have been condensed as much as possible and the findings are compared only to the standards set by the American Academy of Pediatrics.

The findings of the survey have been divided into five parts: Structure of the Nursery; Housekeeping in the Nursery; Special Measures for Protection From Infection; Immediate Care of Baby, and Daily Care of the Baby. Care of mother's breasts and transportation of baby from nursery to mother's bedside are considered under Special Measures for Protection From Infection.

STRUCTURE

Size of Unit: The recommendation is for units of eight bassinets and that there be "no more than 12 bassinets." A small unit provides for greater safety for the baby. He comes in contact with fewer people.

In actual practice more than half of the hospitals have more than eight bassinets in a unit, while others vary from 77 in the nursery to individual cubicles. How many of the hospitals that reported units of "more than eight babies" have units of 12 babies is not known.

In regard to individual cubicles for clean nurseries, the American Academy of Pediatrics says: "Many feel that this single cubicle gives a false sense of protection, takes a great deal of space, is difficult to keep clean, and makes it harder for nurses to work."

Unrecorded in the survey are the number of hospitals which indicated they have large bassinet carriers in the nursery. These hospitals are out of line with the recommendation that there be "at least 2 feet of space separating all bassinets."

Examining Room: About half of the hospitals (42) reported that they had a special room off the nursery for the baby's examination by the doctor. This is in accord with the accepted policy. The baby is taken to this room to be examined so that the doctor need not come into the nursery. In this way the contacts of babies in the nursery are more limited. The fewer people coming in contact with the baby, the better protection the baby has and the less chance of getting an infection.

Lights: About one-third of the hospitals have ultraviolet lights installed. The American Academy of Pediatrics speaks of methods of air disinfection as being "useful adjutants to aseptic technics," and says that "the human factor is of the greatest importance in the protection of infants from infection. Installations are indicated where there exists potentially a significant incidence of cross-infection or a serious risk to patients."

HOUSEKEEPING

In this section are considered methods of cleaning: cleaning of floor, wall and bassinet; care of soiled formula bottle, and whether contact is broken in the nursery between groups of patients.

Methods: Table 1 indicates that the majority of the hospitals follow the recommendation for daily damp dusting and cleaning although a few still do dry dusting and even dry sweeping.

Floors: It is a little difficult from the data to know the exact number of hospitals whose policy is to clean the nursery floor when the babies are out of the room. This is the recommendation. However, 16 hospitals replied definitely that the babies were at the breast during cleaning time. Probably it is safe to assume that more than one-third and less than one-half did their cleaning at the proper time.

Although most hospitals cleaned nursery floors daily, three hospitals

This article, which is an excerpt from an unpublished survey "Current Practices in the Care of the Newborn," written by Miss Latham in 1951, will be presented in two sections. Part 2 will appear in the October issue of this magazine.

[1] American Academy of Pediatrics Committee on Fetus and Newborn, "Standards and Recommendations for Hospital Care of Newborn Infants."

Table 1—Methods of Cleaning

1. Daily wet dusting and sweeping	75
2. Other than wet dusting and sweeping	
a. Daily dry dusting and sweeping	2
b. Daily dry sweeping and daily wet mopping	1
c. Daily dry dusting	1
d. Daily dry dusting and sweeping and daily wet dusting	1
e. Daily dry dusting and sweeping and daily wet dusting and wet mopping	1
3. No reply	2

Table 2—Throat Cultures

A. Nurses assigned nursery	23
B. Interns assigned nursery	4
C. Auxiliary in nursery	20
D. Personnel in formula room	19
E. Other	
1. Only formula room personnel	1
2. Only on auxiliary personnel	2

Table 3—Masks

1. Are they worn by	
a. All personnel entering nursery	33
b. Visiting doctors only	18
c. Other:	
1. Visiting doctor and house staff	4
2. Everyone except nursery personnel	1
3. Nurses and doctors	1
4. Nurses only	1
5. All personnel except nurses	1
6. All personnel from September to May	1
7. Nurses when they have colds; visiting doctors not always	1
d. No masks used	22
2. Are masks changed	
a. Every 2 hours	11
b. Every 4 hours	17
c. Unspecified time	21
d. Other	11
(2 hospitals reported use of paper masks)	

Table 4—Headgear

Covering on head worn by	
A. Nurses	48
B. Interns	33
C. Visiting men	33
D. Auxiliary personnel	45
(6 hospitals reported hair nets worn in place of covering on head)	

reported this done bi-daily, while another reported mopping the floors four times each day, and another twice weekly.

There was a remarkable variety of solutions (16) used to cleanse the floors. Soap and water was reported with the greatest frequency. The effectiveness of some of the solutions might be questioned as, for example, just water. The advisability of using creosol or ammonia is an interesting question on which bacteriologists might like to comment. No hospital mentioned using oil or a solution with oil in mopping the floor.

Walls: The American Academy of Pediatrics is not specific on frequency of wall washing nor does it mention vacating one nursery, cleaning it completely, and then admitting a new group of patients to it. The standards do state that "walls, ceilings and floors of nurseries . . . should be constructed of nonabsorbent material that can be washed." In practice, there does not seem to be any particular pattern followed. Almost one-third of the hospitals say there is no definite time for wall washing, while more than one-third state that one nursery is not vacated at any time. Consideration of these two facts combined gives evidence that there is no pattern for completely cleaning the nursery at any time.

Bassinet: In general housekeeping, it is of interest to note almost all the hospitals in the survey (83) washed the bassinet after the baby's discharge and that the majority (72) have a plastic or rubber material covering the mattress. The latter can be washed easily. Among solutions used to wash or disinfect the mattress after discharge of the baby are the following: lysol, benzalkonium chloride, creosol, and soap and water with alcohol. Two hospitals reported using ultraviolet lamp on the mattress. One hospital autoclaved the mattress.

Soiled Formula Bottle Nipples: The American Academy of Pediatrics recommends that soiled bottles and nipples be rinsed with running water and returned to the formula room after every feeding. In actual practice, there is considerable variation. Although almost one-third of the hospitals rinse nipples with cold water, then place them in dry container, other hospitals place the nipples in soap solution and in germicidal solutions. One hospital reported boiling nipples three minutes in the nursery. In all there were 21 ways of caring for the nipples and seven solutions were named, other than hot or cold water, which are used in the nursery before the nipples are returned to the formula room.

The practice of leaving nipples in any solution to soak may be ques-

tioned from two points of view: one, the nipples become soft, and two, there is the possibility that a harmful drug might be dropped into the solution by accident.

Forty-three hospitals said that a can of sterile nipples was left in the nursery. In regard to all sterile supplies in the nursery (nipples included) I would like to point out that, unless they are resterilized at frequent intervals, they are a potential source of danger. Actually, the practice of having the extra sterile nipples in the nursery is against the recommendation of the American Hospital Association, which urges that "hospitals make a rigid rule prohibiting change or removal of nipples for any reason during feeding. Substitute another bottle of formula rather than risk contamination by changing the nipples."

PREVENTION OF INFECTION

In this section is considered mask and gown technic, health of personnel, headgear of adults in nursery, hand washing, use of common baby bathing table, method of taking temperature, frequency of weighing, transporting baby from nursery to mother, cleanliness of mother's hands, and breast care of the mother.

The Health of Personnel: The "Standards and Recommendations for Hospital Care of Newborn Infants" states that preemployment physical examination should be implemented by such laboratory studies as x-rays of the chest, and nose, throat and stool cultures.

Throat Cultures (See Table 2): Although the questionnaires yielded information about throat cultures (less than one-third of nurses assigned to the nursery and formula rooms had cultures taken), a few hospitals volunteered information about x-ray examinations of the chest. Three specified that personnel (nurses and auxiliary help) had x-ray examinations as well as throat cultures. One hospital stated that after leave of absence or return to duty from illness a complete examination was done. In addition to this the same hospital said any person having sore throat, skin lesion, or indications of illness was removed from the nursery. Another hospital stated that the chief of pediatrics and the pathologist did not believe in taking throat cultures routinely in the absence of clinical symptoms. Two hospitals stated that new personnel wore masks until the reports of the throat cultures and x-ray test were obtained.

Masks: From Table 3, the practice is seen as follows: that 33 hospitals require all personnel to wear masks, 18 have only visiting doctors wear them, and 22 report no masks worn by anyone. One hospital stated that everyone except nursery personnel wore

Table 5—Place of Cleansing Baby

1. Baby's own crib	54
2. Baby bathing table	22
3. Other:	
a. Worktable	1
b. Space in front of individual crib	1
4. Unspecified	1
5. No answer	4

Table 6—Method of Temperature Taking

a. Rectal	72
b. Axillary	11

Table 7—Method of Transporting Baby from Nursery to Mother

1. One at a time in bassinet	18
2. One at a time in nurse's arms	27
3. In large carrier	32
4. Other:	
a. Two at a time in bassinet	2
b. One at a time in bassinet for private room; for ward, four-baby carrier	1
c. Four at a time in own bassinets	2
5. No answer	2

Table 8—Cleanliness of Mother's Hands

A. Does she wash them	47
B. Other:	
1. Alcohol, 70%	2
2. Alcohol	10
3. Saline wipes	1
4. Benzalkonium, solution of	1
5. Benzalkonium sponge	6
6. Benzalkonium chloride, cotton swab	1
C. No washing or cleansing reported	12
D. No answer	2

Table 9—Care of Nursing Mother's Breasts

A. Nipples cleansed with	
1. Soap and water	31
2. Boric	15
3. Saline	5
4. Water	14
5. Other:	
a. Aqueous benzalkonium 1:2000	1
b. Aqueous benzalkonium 1:1000	1
c. Aqueous benzalkonium	2
d. Alcohol	1
e. Boric and 35% alcohol	1
f. Distilled water	1
g. Green soap, water rinse	1
h. Saline and hydrogen peroxide	1
i. Soap, water and alcohol	1
j. Soap, water and boric	1
k. Soap, water and benzalkonium	1
l. Sodium hypochlorite 1%	1
m. Sterile water	3

masks. Perhaps this last hospital and the 18 who used masks for visiting men knew the health condition of their personnel and believed that others (doctors, laboratory technicians, maintenance department people) constituted a variable factor. That people who have colds are allowed in the nursery is evidenced by the hospital that reported that nurses wore masks *when* they had a cold.

The American Academy of Pediatrics states that if masks are required by the medical staff they should be so made that they are effective in preventing droplet infection and they should be changed frequently—at least every two hours. It should be appreciated that handling or adjusting the mask contaminates the hands and indicates washing. (Of 33 hospitals who reported masks for everyone, 11 said masks were changed every two hours, 17 said masks were changed every four hours, and others varied from every eight hours to daily. In other words less than half complied with accepted standards.)

Nurses' Dress: That 51 hospitals used a special dress for nurses in the nursery in place of a uniform is not surprising but that six hospitals did not report the use of either a special dress in place of a uniform, or a gown or apron over the nurse's uniform, is an unexpected finding. Worthy of note are the three hospitals that have nurses wear a gown over their special dress when going outside the nursery, as in taking the baby to the mother. In other words, the nursery is cleaner than the ward. Nine hospitals do not report that interns wear gowns when handling the baby, and three hospitals do not report that visiting doctors wear gowns.

Headgear: Perhaps the purpose of head covering for doctors and nurses in the nurseries should be examined. If the purpose is for nurses to keep their hair from contact with baby, then would not a hair net suffice? Six hospitals reported the use of hair nets instead of a special head covering. The board of health in one large middle western city granted permission to one hospital to omit the use of special headgear. It would be of interest to know if any ill effects occurred in the 35 hospitals where nurses wear no special covering for their hair, or in the 50 hospitals where doctors wore no caps.

The recommendation is: "If the use of caps is required by the medical staff, they should completely cover the hair."

Handwashing: The recommendation says, "Jewelry should be removed and strict handwashing technic using a metal nail file to clean nails should be maintained by physicians and nurses. Hands should be washed with soap or a detergent and running water before and after handling, diapering or feeding each infant. It is essential that lavatories be conveniently located inside each nursery as well as in each room."

Perhaps the most significant findings in the survey are: (1) that neither all nurses nor all doctors wash their hands after handling the baby, (2) variation in handwashing technic, and (3) number of different soaps used. Hospitals varied as to use of brush, length of time scrubbing (3 minutes, 1 minute, or 10 minutes), and solutions used. Seven hospitals had employes soak their hands in a special solution instead of washing them. The specific names of 13 soaps were reported used, and a combination of 29 different solutions and soaps. Even so, 19 hospitals did not specify the types of soaps doctors and nurses use in the nursery.

Bathing Table: A common bathing table is a potential source of danger relative to infection; however, Table 5 shows 22 hospitals or almost one-third of the hospitals on the survey are using them still. The recommendation that a common bathing table not be used is even underscored in the booklet "Standards and Recommendations for Hospital Care of Newborn Infections."

Weighing: The recommendation from the American Academy of Pediatrics is for daily weight the first four days: "Then only every other day, or in some cases, only twice a week."

Olsen and Clifford[2] point out that reducing the frequency of weighing reduces the possibility of infection by daily use of the common scale.

In practice over half of the hospitals[3] weighed babies daily, while 11 reported every other day. Two hospitals stated they weighed babies daily unless under six pounds, then every other day. Other practices varied.

Temperature Taking: An axillary temperature is the recommendation, however, in practice (see Table 6) more than three-fourths of the hospitals (72) take a rectal temperature while only 11 hospitals follow the recommendation.

Transportation of Baby: In transporting the baby from the nursery to the mother, the most commonly accepted method was the use of a large baby carrier. The next most popular method was in the nurse's arms, and the least favored method was by the use of the baby's own bassinet. The last method is the recommendation.

Also the survey revealed (Table 8) that 12 mothers neither washed nor cleansed their hands before nursing the baby. (Unfortunately, the survey did not include information as to possible instructions given to the mother regarding washing her hands after touching her perineal pad or after perineal care.)

Breast Care: In regard to care of the breasts, it is recommended that "if the mother is bathed daily and wears a binder no special preparation or washing of the breasts is necessary before feeding. If provision is made for the mother to wash her hands after using the bedpan, there is no need for her to wash before nursing the baby."

In contrast to this, the survey found that about half (44) of the hospitals cleanse the mothers' breasts before nursing, while 31 hospitals indicate that mothers' breasts are washed only at bath time. A few hospitals cleanse the breasts both before and after nursing. One hospital volunteered the information that a clean washcloth was given to the mother each day and that she washed her nipples and breasts before the rest of her body.

Solutions which are used to cleanse breasts (other than soap and water at bath time) bear scrutiny. (Table 9.) Ten different solutions are used, while several hospitals use a combination of solutions as soap, water, and benzalkonium. One hospital uses aqueous benzalkonium 1:2000, while another uses aqueous benzalkonium 1:1000. Alcohol is used by two hospitals, one combining it with boric and another using it alone. Of real concern are the 15 hospitals who use boric alone.

As far as the use of alcohol is concerned, it is an astringent, which hardens the nipples, thereby favoring the formation of cracks through which infection may enter.

(To be concluded in October issue.)

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[2] Olsen, R. M., and Clifford, N. L.: Nursing Techniques in Maternity Hospital. Am. J. Public Health, **35**:1119 (November) 1945.

[3] Parsons, Leonard: Prevention of Neonatal Disease and Death. Lancet, **1**:267 (February) 1944.

Who Needs Training More Than the Admitting Clerk?

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Rôle playing is one fruitful method of teaching clerks proper admitting procedure.

FIRST impressions are generally lasting impressions, and it has long been recognized in the hospital field that the impression the admitting officer makes on the incoming patient can make or break the patient's adjustment to the hospital. We all realize that the patient is not in a normal state of mind, nor are those who accompany him to the hospital. It is, therefore, doubly important that the admitting clerk exercise all the tact and diplomacy at her disposal to make the patient's welcome a warm one. If this has been successfully accomplished, it usually follows that the patient makes this satisfactory adjustment and continues to maintain a happy frame of mind throughout his hospitalization, all other factors being equal.

Unfortunately, it is not sufficient that the admitting clerk be possessed of a charming personality, together with a superabundance of diplomacy and tact. She must have facts and information at her disposal which she can pass on to the patient in answer to questions which inevitably arise during the course of the usual hospital admission. It has been said that the admitting officer should be thoroughly familiar with not only government laws and regulations concerning hospitals and patients, but with procedures of insurance companies, pension plans, Blue Cross, workmen's compensation acts, and so forth. The admitting officer should be familiar with the general policies of the hospital and with those specific policies which relate to the admission of patients. She must recognize which doctors are on the medical staff and which are not allowed to utilize the facilities of the hospital. She should be generally conversant with the economic operation of the hospital so that she can answer questions pertaining to rates, the manner of statement settlement, and time payment plans. Someone has said that 95 per cent of all collections can be provided for at the time of admission. Certainly, the admitting clerk is in much better position to carry out this function if she is in possession of the necessary facts concerning the operation of the hospital which will allow her to answer the questions that so often arise.

The training of admitting clerks is a valid responsibility of the assistant administrator. There are many ways in which this responsibility may be discharged. The immediate supervisor of the admitting clerk has a great share in any training program of this sort. In hospitals which have personnel departments, the assistant administrator should be able to call upon it to provide help in on-the-job training courses and in indoctrination programs designed to make the operations of the admitting department more efficient.

Admitting department personnel should receive, first of all, that ordinary indoctrination and orientation which is extended to all employes. This can be done formally through the personnel department or the immediate supervisor, or it can be done more or less informally by the employe's fellow workers. I prefer the more formalized indoctrination, inasmuch as it leaves so little to chance insofar as providing correct information to the employe is concerned. We are fortunate in having a personnel department which takes care of this function. The usual indoctrination of employes consists of information concerning rates of pay, job titles, the need for a uniform and the type of uniform, method of payment, health examination requirements, vacation, sick leave and holiday policies, our health insurance group, the time clock, and a map of the hospital.

In addition to the indoctrination provided by the personnel department, it is necessary to provide specific training in jobs as specialized as that of an admitting clerk. The admitting clerk should be familiar with the job description for her particular position, with the responsibilities she is expected to discharge, and with the policies necessary for the discharge of those responsibilities. We propose that the purpose of the admitting department will be to admit patients to the hospital, in accordance with policies and regulations established by our governing board and executive office, in such a way as to promote good relationships with patients, relatives and the medical staff. The admitting office will have the responsibility for determining the medical, financial and geographical eligibility of patients for admission to the hospital. Their functions will revolve about the admitting, transfer and discharge of patients. In our organizational structure, the admitting clerk will report directly to a supervisor in the business office who is under the general supervision of the

assistant administrator. While we have not as yet adopted the United States Department of Labor program, it affords an excellent starting point in the training of admitting clerks. This program is approximately as follows:

Job Summary.—Determines eligibility and arranges for admission of patients to hospital; interviews patients or relatives to obtain necessary personal and factual data; assigns accommodations; prepares records of admission, transfer and other data that may be required; initiates notice of patient's admission to pertinent departments; supervises admitting office personnel (this refers to the admitting supervisor); performs related duties.

Special Demands.—Ability to meet and deal with patients, visitors and relatives; is not disturbed by nature of patient's illness; considerable initiative and judgment involved in planning payment of accounts and determining eligibility for admission; procedures are well standardized, although worker adapts interview to type of patient being admitted; works under general supervision; may be required to work different shifts, holidays and Sundays.

Job Knowledge.—Must have a general knowledge of hospital operations and procedures and be familiar with principles of applied psychology, technic of interviewing, and methods of establishing patient's financial status and eligibility for admission.

VESTIBULE TRAINING WORTH WHILE

Any of us would be happy to have an employe apply for the job who is in possession of all the qualifications which have just been enumerated. The people who come to us fully prepared to carry out their duties are few and far between. However, if we add that the employe should be chosen on the basis of a pleasing or charming personality, should have tact, gentle kindness and willingness to be of service to others, but, with all, an unswerving firmness, we come up against such extreme demands that if we are successful in finding such a person, we wonder why he is willing to settle for a job at the level of an admission clerk. To me, it seems much more realistic to assume that the persons who come to us for jobs of this type will not be in possession of these qualifications and that we will have to make every effort to fortify them with any aids we are in a position to supply, and this can be best done through on-the-job training.

Before we proceed further, it might be well to discuss the possibility of vestibule training for this type of work. Vestibule training can be defined as that which is given to an employe after he has been hired, but before he is actually placed on duty. He has passed through the front door, but is not yet in the parlor. Those who advocate vestibule training claim the following advantages:

1. More efficient use can be made of the instructor's time and skills.
2. Regular work is less impeded by beginners who are not familiar with the job.
3. The general atmosphere is more favorable to learning.
4. Stress can be laid on those aspects of the employe's knowledge of the job which are weak and which may well be the most important.
5. The employe *begins* the job properly equipped to handle it, insofar as training makes this possible.

If this type of training did nothing else but prevent an admitting clerk from greeting a patient with a snarl instead of a smile, it would earn an everlasting place in my gratitude file. We have not fully explored the possibilities of this avenue of approach at our hospital, but we are going to look into it carefully and see if we can't reduce the amount of time spent in on-the-job training and increase the time spent in vestibule training.

No matter what type of training is used, it is most important that the desired results be achieved. We must supply to the admitting clerks policies which have already been solidified, and we must provide a proper physical atmosphere in which to work. In addition, and most difficult of all, we must instill in them the various attributes we have already discussed.

There are many methods which can be used in employe training. Among these are rôle playing, the visual means, and the conference technic. For a position as important as that of admitting clerk, it seems to me we should carefully investigate all methods of employe training before any of them is discarded. I believe we should go so far as to train our admitting clerks not only in what to say but in how to say it and at what times to say it. If this seems rather drastic, I would refer you to the training programs which have been in effect in telephone companies for many years in which the operators are instructed along these very lines.

Rôle playing seems to offer the most fruitful ground for a really successful training program for admitting clerks. Through this method the most trying moments of the admitting clerk could be brought forth in all of their grim glory. We could confront her with the irascible patient who didn't like the room to which he had been assigned; with the doctor who insisted that his patient be admitted even though he was aware, and was willing to admit, that it was really not an emergency case; with the difficult relative who knew exactly how her dear sister should be taken care of; with the distraught nursing supervisor, who suddenly found that patients were streaming on to a floor which was understaffed to begin with. All of these things could be done before the admitting clerk ever entered into duty. They could be presented to her in such a way that she would become accustomed to them and their proper handling.

We envision that our admitting clerks will know as much about our hospital, if not more, than any other person connected with the institution. We envision a complete tour of the hospital, with a complete explanation given by each department head of that department's function in the over-all activity of the hospital. We envision that utopia which will be reached when there is no question proposed by a patient that the admitting clerk will not be able to answer to the complete satisfaction of the patient.

PROGRAM STILL DEVELOPING

It will be noted that I have been extremely careful to use the word envision. Our program is very much in the developmental stage, and after reviewing the complexity of it, I am happy that it is the responsibility of the assistant administrator. All we have to do now is to find capable candidates for our positions who will be able to work week ends and evenings and on Sundays and holidays and who are in possession of all of the attributes we have listed. When this is done, I am sure we will have little or no difficulty in outlining a good training program.

At present, we are also using the conference technic. This consists simply of bringing together as many of the admitting clerks as we can possibly assemble at one time and having them enter into a discussion with their immediate supervisor and with the assistant administrator. In this manner it is possible to keep all persons con-

cerned up to date concerning any changes in policy which might be of interest to them.

In addition, we can also provide them with an opportunity to ask questions which confront them in the performance of their duties. This technic gives us a straight line liaison between administration and the admitting office, and at the same time provides an opportunity for the development of supervisory personnel because of the participation of the immediate supervisor in these conferences. We have used this method so short a time that it is quite impossible to evaluate its effectiveness, but from our early experiences we feel encouraged to continue this method as one of the technics of instructing admitting clerks when our formal program is put into effect, particularly since it will provide a constant back check on the effectiveness of our training program.

The most important thing to consider in a discussion of this sort is not how we will do it, but the fact that it should be done. There is no area in the hospital that requires a more highly trained person, public-relations-wise, than the admitting office. We would not be performing our duty if we did not make sure that those who admit the patients into our hospital are as highly trained as our facilities and our training skills will permit.

They Made Hospital History

BENJAMIN RUSH

OTHO F. BALL, M.D.

"We find the most acceptable men in practical society have been those who never shocked their contemporaries, by opposing popular or common opinions. Men of opposite characters, like objects placed too near the eye, are seldom seen distinctly by the age in which they live. They must content themselves with the prospect of being useful to the distant and more enlightened generations which are to follow them. Galileo, who asked pardon of the Pope on his knees for contradicting the *common sense* of the church respecting the revolution of the earth, and Dr. Harvey, who lost all his business by refuting the *common sense* of former ages respecting the circulation of the blood, now enjoy a reputation for their opinions and discoveries, which has in no instance ever been given to the cold blood of common sense." (*Benjamin Rush: Thoughts on Common Sense. In his "Essays, Literary, Moral and Philosophical." Philadelphia, 1806.*)

This article on Benjamin Rush, which will appear in this and the October issues of The Modern Hospital, was prepared shortly before Dr. Ball's death in July.

BENJAMIN RUSH, who numbered among his intimate friends Benjamin Franklin, John and Samuel Adams and Gen. Charles Lee, has been considered by many as the greatest American physician of his era; he has also been called a pseudo-scientist, a self-opinionated, overestimated man. Even long after the medical world had forgotten the desperate quarrels in which he was constantly embroiled, and remembered only his eminence as a medical man, armchair professors ruthlessly decried the "Myth of Benjamin Rush," and heatedly revived the many errors with which he had been charged. To judge men long dead in the light of accumulated knowledge is manifestly unjust.

Rush was in the thick of every important event during the years of the Revolution and in the formulative years that followed. An ardent patriot, social reformer and humanitarian, organizer of scientific and philanthropic societies, he was the pivot point of continuous quarrels among the profession. As a member of Congress, he signed the Declaration of Independence. He advocated prison reforms and the abolition of slavery, initiated the temperance movement in this country, and assailed the treatment of the insane.

He was the first to suggest infected teeth as a source of infection; the first to suggest therapeutic mental catharsis, now termed psychoanalysis. He attacked the old beliefs that childbirth pains are indispensable in aiding the uterus to discharge its burden and, moreover, that these pains are a punishment for the sin of Eve. He expressed the hope that a medication would be found to suspend the sensibilities of the nerves in childbirth, without impairment of their sensitivity, thus foreshadowing obstetrical anesthesia. He wrote on diet, effects of climate, military hygiene, leprosy and yellow fever.

Ardent, even bellicose, in promoting his beliefs, he was so often right, so frequently wrong. "His bold and exuberant imagination led him to adopt some theories not wholly founded on truth. But they show the march of a mind grand in conception, sublime in result."[3]

"His conduct in the crises of his

life cannot be understood unless we realize that he was always pathologically sensitive about his rights and honors and that when he was in a bad temper, which was often, his tongue and still more his pen got out of control. This sensitiveness was partly due to his ambition which in a quiet way was so great that it was bound to be frustrated. . . . His very kindness and philanthropic spirit contributed to his irritability, for he could never be patient with those who were, in his opinion, exploiting or oppressing other people. . . . To this sensitivity was added a cocksureness and insistence about his own opinions that kept him during many years of his life involved in one major controversy or another."[1]

In belligerent defense of his beliefs, he often walked alone, and appeared not to care. That he did care and wished to explain and justify his many antagonisms is shown in his autobiography written in 10 short notebooks for his children, who long regarded his wish that the manuscript should never be printed. It is fortunate that it fell into the hands of a scholarly critic,[1] who published it at length, with annotations explaining many of the data presented by Rush. This autobiography confirms in many ways the evaluation of his early admirers. He hides none of his faults, but reveals what brought them about. With all the evidence in, the verdict can only be that Benjamin Rush was one of the great men of his era.

"Rush has been called the American Sydenham, first by Lettsom who said of him that he approached if not exceeded Sydenham in grandeur and compass of thought. By his American admirers and eulogists he has often been spoken of as the American Hippocrates. Hack Tuke ('The Insane in the United States and Canada,' London, 1885) preferred to call him the American Fothergill, saying that he resembled Fothergill in the independence of his medical practice; in acuteness of observation; in his incessant labor; in popularity as the leading physician of the day in a great city; but, above all, in uniting with the functions of a physician the philanthropy which manifested itself in innumerable practical suggestions for the benefit of his kind."[6]

Benjamin Rush was born in 1745 in Byberry, near Philadelphia. When his father, John Rush, died five years later, leaving a small estate, his mother

BENJAMIN RUSH
(1745-1813)

opened a store where she sold groceries and liquor; later she opened a china shop. She was energetic and prospered and reared and educated her six children. She married again, a distiller, and after his death, lived with Benjamin and his splendid wife. Benjamin reared nine of his own 13 children.

With his brother Jacob who became a prominent lawyer and a judge of the high court of appeals in Pennsylvania, Benjamin entered the school of his maternal uncle, Rev. Dr. Samuel Finley in Nottingham, Mass. Under Finley, destined to become president of the College of New Jersey (Princeton), he acquired a taste for classical literature, a habit of study and observation, and a deep reverence for religion and the duties it imposed.

Graduated from Princeton in 1760, he began the study of medicine under Dr. John Redman, leading physician of Philadelphia. With one other apprentice, Rush prepared medicines, visited the sick and performed many of the duties of a nurse. He spent no more than three evenings away from the home of Redman during his six years' apprenticeship. He closely observed the work of Redman and five associated medical men at the Philadelphia Hospital, and at the Pennsylvania Medical School attended lectures by Shippen on anatomy (1762, 1765) and Morgan on materia medica (1765). There he acquired a life-long admiration for the works of Sydenham.

More than apt as a student and thoroughly trained by Finley and Redman, Rush entered the University of Edinburgh in the fall of 1766 and received his medical degree two years later. Among the celebrated professors of that school was William Cullen, whose method Rush determinedly followed for many years. He wrote: "I had learned from my master Dr. Cullen to give but few medicines in diseases, and to rely more upon diet and drinks than had been common in Philadelphia. . . . Several of the old and established physicians of the city became unfriendly to me in consequence of my having broached some parts of Dr. Cullen's system of medicine in my lectures. This system was built upon the ruins of Dr. Boerhaave's, which was then the prevailing system of medical principles and practice in America. I do not recollect in the course of the first seven years of my settlement in Philadelphia that any one of my brethren ever sent a patient to me, and yet several of them had more applications daily than they were able to attend to. The system of Dr. Cullen was calumniated and even ridiculed in the newspapers with my name connected with it. . . . However unpopular and offensive the system of Dr. Cullen was when first broached by me, I lived to see it adopted by all the physicians who had opposed it; nay more, I lived to see it adhered to and defended with great obstinacy when an attempt was made to alter and improve it twenty years afterward." Rush admitted his want of tact. "Perhaps my manner of recommending it provoked this opposition, for I know by experience as well as observation that an indiscreet zeal for truth, justice or humanity has cost more to the persons who have exercised it than the total want of zeal for anything good, or even zeal in false and unjust pursuits." (Autobiography.) It was this untactful emphasis on what he believed to be true that kept Rush continually at war with his contemporaries.

After his graduation Rush attended the lectures and dissections of William Hunter in London, visited the classes of Huck at the Middlesex Hospital and followed him to St. Thomas's. There he met Sir John Pringle, physician to the Queen, and attended his weekly conversation parties. Once a week he breakfasted with Dr. John Fothergill, the famous Quaker physician. Rush lived in the home of Benjamin Franklin, then London agent to several of the American colonies, and met his influential friends. He took

to Paris letters of introduction from Franklin and reluctantly accepted from him a letter of credit upon a bank in Paris for several hundred guineas. Rush was later glad to draw out 30 guineas, which he gratefully returned to Mrs. Franklin in America.

Rush visited la Charité of Paris and found it neat and clean, but was appalled at the crowded, odorous Hôtel Dieu with its beds containing four patients. He visited the Foundling Hospital where, the night before, 20 babies had been placed in turn in the cradle outside the door.

On his return he immediately set up practice in Philadelphia. He was then 24 years old (1769). With no influential connections, he called to mind Boerhaave's words that the poor were his best patients because God was their paymaster, and that Cullen in Scotland and Fothergill in London had established themselves by extensive practice among the poor. Rush began his own practice among the poor, not an unpleasant task for a man so humane. His patients lived all over the city and in the suburbs. He visited them afoot, going into every street and alley, sometimes climbing a ladder to the second floor and resting upon the bed of the patient in the chairless room, risking both vermin and infection. He rarely was paid.

His practice gradually increased, amounting in 1775 to more than 900 pounds. His office was crowded with the poor in the morning and at mealtime; the rest of his time he devoted to his paying patients. Always he practiced a life of self-denial. After 1789 he rarely spent an evening outside his home.

Immediately upon his return to Philadelphia in 1769, he had been elected professor of chemistry in the College of Philadelphia. In 1789 he succeeded to the chair of the theory and practice of medicine, vacated by the death of Henry Morgan. When he was 46 the College of Philadelphia merged with the University of Pennsylvania and he was made professor of the institutes and practice of medicine and clinical practice. In 1796 he became professor of the practice of physic. He remained in these three offices until his death.

For 30 years Benjamin Rush served as physician to the Pennsylvania Hospital (1783-1813), and "such was his punctuality, his love of order and his sense of duty, that he not only made his daily visit to that institution, but was never absent 10 minutes after the appointed hour for prescribing. . . . What Boerhaave was to the medical school of Leyden, or Dr. Cullen to that of Edinburgh, Dr. Rush was to the University of Pennsylvania."[3]

When five members of Congress from Pennsylvania declared the Declaration of Independence was premature and bolted, Rush, already in the thick of the fray, was elected to fill one of the vacancies. His plain signature stands between those of Benjamin Franklin and Robert Morse. He served in the Continental Congress for nine months doing routine work, but was not reelected in 1777, after he had denounced his state government as tyrannical.

It was during the war that Benjamin Rush first came into serious trouble. In April 1777 Shippen became director-general of the medical department of the army and Rush was made surgeon-general of the middle department and a few months later, physician-general. It is noteworthy that he always refused pay for his public service. He was outraged at the condition of the military hospitals, the lack of beds, blankets and medicines, the poor food and the lack of competent doctors. By fall he was denouncing the administration of these hospitals again and again to his friend John Adams, and threatening to resign if conditions were not improved. Adams was working over time on state matters and only tried to calm him. Shippen ignored Rush's appeals for improvements. Rush complained bitterly when he found 5000 soldiers in a hospital with supplies for 1500 and another hospital with drunken patients and no officers to maintain discipline. Just before Christmas in 1777, Rush complained to Washington himself, but Washington was fighting cold and hunger at Valley Forge and when he finally got around to replying, Rush had already resigned. Congress summoned Shippen and Rush to appear before that body and Rush, cheered by the thought that something was to be done, reconsidered his resignation. But Shippen declared he would not serve unless Rush resigned and, as there now seemed no prospects for reform, Rush handed in his resignation which was accepted by a Congress heartily sick of the fracas.

"His wrath was that of an honest doctor whose patients were being tortured by official neglect; his aim was patriotic. But right as he was about the medical abuses and probably about Shippen's incompetence, his hasty temper and his angry pen had cost him his chance to serve the country in war."[1]

In his impetuous zeal for the welfare of the sick soldiers, Rush had committed his greatest error. He wrote an anonymous letter to Patrick Henry with an account of conditions and quoting a speech of General Conway in which he criticized the talents of the commander-in-chief. Washington identified the letter as coming from Rush. This caused Rush's name to be unjustly linked with the Conway Cabal which sought to remove Washington from his command of the Continental Army. Later the wound was healed and Rush became a warm admirer of Washington and entertained him in his home.

At Rush's insistence Shippen was finally courtmartialed but acquitted. Rush was enraged and continued to hurl charges against him. Shippen finally resigned in the beginning of 1781.

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Small Hospital Forum

They Seldom Steal Marked Property

EDWARD W. GILGAN
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THE control of pilferage in a hospital sometimes seems to defy all attempts at solution. Each hospital, of course, has its own particular problems, which makes it difficult to establish rules that are applicable to all.

In addition to controlling thefts by personnel, hospitals must check on patients and visitors as well. Hotels usually have only two entrances, one for the employes and one for guests, with a checker stationed at the employes' entrance to examine packages. If hospitals would profit by this example, and have all packages inspected at the employes' entrance, much of the problem could be solved at this point. A careful analysis of the theft losses must be made. If they are trifling, an elaborate system of checks, which involves additional labor, may be more expensive than the articles stolen.

If a study of patients' habits reveals that they belong to that special breed —the American Souvenir Hunter—it is wise to make some effort to satisfy this collector's desire. This can be done with an ash tray, an attractive salt and pepper shaker, or some other inexpensive item. This should be marked with the hospital's crest and name. If it is attractively wrapped in a nice gift box, and labeled "A souvenir of your stay at the Memorial Hospital," it will satisfy that desire for collecting. A silver coffee pot, a blanket or towel with the hospital's name is a little too expensive.

A small souvenir will have the added value of promoting good public relations. When the patient returns home the inexpensive gift will be displayed to friends, and comments on his enjoyable stay at the hospital will be expressed.

Much of the problem of theft can be solved if the tray service (which is frequently abstracted) is properly marked. For example, at our hospital we find it desirable, in order to eliminate breakage and to keep a supply of cold water at the patient's bedside, to use unbreakable vacuum water pitchers. To prevent pilferage of this equipment we had the pieces etched as shown so that the patient would not want to take them home or to display them as souvenirs:

Presented to
Ryburn Hospital
by
Knights of Columbus

It has been my experience that this technic will, in large measure, overcome the souvenir hunting instincts of many guests and employes. If these servers or vacuum water pitchers for bedside service are presented by the women's auxiliary, the Rotary Club, or an individual, the problem can be solved very easily. Such a gift should be marked:

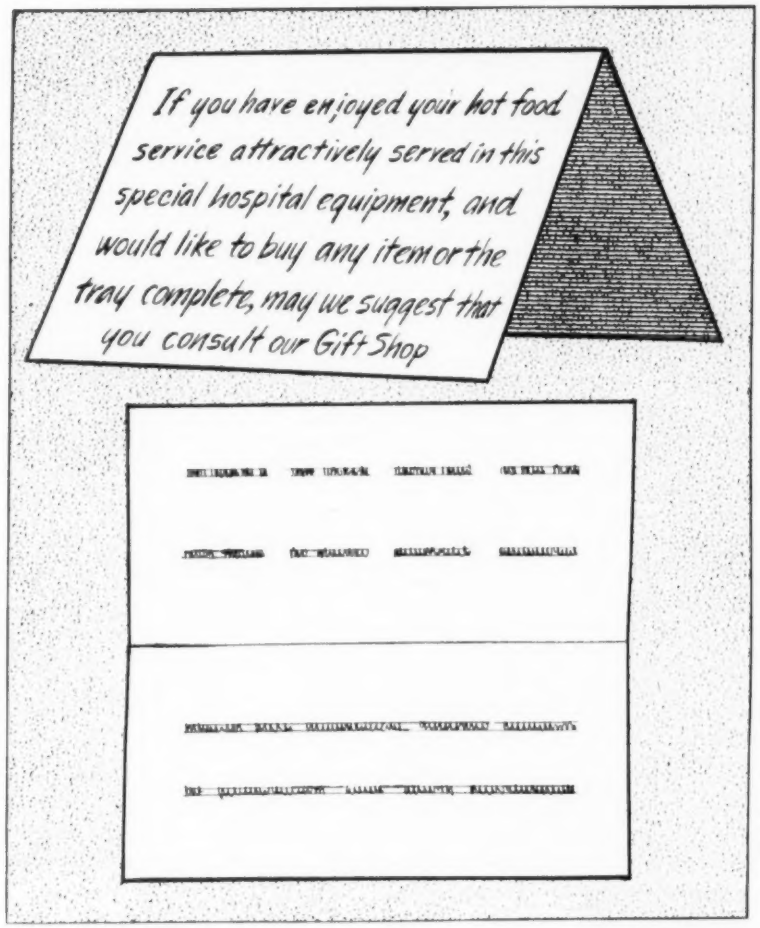
Presented to
The Memorial Hospital
By
The Ladies' Auxiliary

No patient, employe or visitor would have the nerve to carry away an article so marked, or to display it in his home. I am, of course, excepting the kleptomaniac. Incidentally, by etching the pieces of equipment the hospital is able to acknowledge and publicize the good work that is being done by community groups and the manner in which funds donated by local organizations are being expended.

If articles are checked out to the patients' rooms, as in the case of the vacuum pitcher for bedside ice water service, and are supposed to be kept in a particular room, the room number can be etched into the handle. The servers may be numbered consecutively or with room number. Provision can be made also for placing the number of the server on the food tray card. Such a procedure definitely establishes in the mind of patients and guests that the server is checked, and if it is not returned some questions will have to be answered: "Where is server 413 that was on your tray?"

Hospital equipment is not easy for the average person to purchase. Such items are usually found only in specialized stores in the larger cities. This inability to purchase adds to the incidence of theft. Suppose a patient is faced with the problem of serving trays and ice water at home for many months after his hospital stay. His room may be some distance from the kitchen and the problem of serving hot and cold foods is just as difficult as it is in the hospital. He will need some equipment to accomplish this service. Where is he going to get it?

Hospital gift shops are usually sponsored by the auxiliary or some other group that turns the profits back into needed equipment of service for the hospital. Every opportunity to bring this gift shop to the attention of patients and their guests should be made the most of. It is suggested that a tent card be used which can be placed on the tray as illustrated. On the outside



Tent card on the patient's tray. It is also shown opened up, with indications of the gift shop items that may be listed there.

of the card will be the following message:

"If you have enjoyed your hot food service, attractively served in this special hospital equipment, and would like to buy any item or the tray complete, may we suggest that you consult our Gift Shop."

If the hospital does not have a gift shop, this may be changed to "Business Office." On the inside of the card should be listed all of the items used on the tray. The price of each item should be shown—not the net price paid by the hospital but the list price, which in most cases will be as much as twice the hospital cost. A letter to the manufacturer of the item in question will quickly produce the correct list price. This will afford the gift shop an opportunity to make a sizable profit, and the profit will more than offset any losses.

Another problem that will be solved with the use of these cards involves public relations. Most people are of the opinion that hospital china is of the ten-cent store variety, and that it costs even less because it is bought in large quantities. They have no idea that a silver sugar, creamer or coffee server costs what it does. If they are paying $12 per day they usually feel they have been overcharged. Establishing the fact that it costs more than $60 to equip each tray will go a long way toward establishing the proper thinking on the part of patients. The column on the left side of the card may be used for checking so that the patient can see that each item has been checked out on the tray. This is a common practice among the better hotels.

Vacuum serving pieces should be kept in a locked cabinet. This may be either metal or wood, but either the front or the rear of the cabinet should be made of hardware cloth for adequate ventilation. The shelves should be so spaced that the lids can remain open while the servers are in storage.

This cabinet should be so constructed that it will hold *only* the number of servers purchased. The problem of counting 100 or more servers after each meal is a difficult one for the average hospital kitchen employe; if he is in a hurry it is easy for him to miss one or two. If the cabinet holds only the number used, any missing service can easily be noted and then proper effort can be made to locate it. It would be well to make the shelves with dividers so that the servers are kept a fraction of an inch apart, thus eliminating careless handling which will result in scratching or denting. Several hospitals have found that rubber bumpers or felt linings on the partitions add to their utility.

One employe should have the key to this cabinet and this person should be charged with the sole responsibility of seeing that these servers are stored. It may add to the convenience of handling if this cabinet is mounted on wheels so it can be drawn up to the serving belt at mealtime and, when not in service, rolled into the hall or the storage area of the kitchen.

Several hospitals have found that by establishing a policy of requiring that all items on the tray must be on it when the tray is returned to the kitchen they solve the problem of loss. If the patient in Room 110 wants to retain her pot of coffee, the pot must first be returned with the tray and then reissued; this is charged to that room and if it is not returned it is charged to the patient's bill. Making it inconvenient for the patient to keep out an item always gives a tighter control.

An unoccupied room should be made up complete with all equipment, checked by the maids, and locked after it is ready for occupancy. It should be unlocked only by the supervisor of the floor. Unoccupied rooms that are open are always a source of pilferage by visitors and employes. If some standard room item is broken it is an easy matter to get a new one from an unoccupied room. The vacuum pitcher in Room 412 cannot be switched by the nurse, or taken away by a visitor from Room 415, if the unoccupied room is locked. The administrator then knows that the unoccupied room is complete and is ready for occupancy.

It is important, when hospitals are being criticized for inefficient operation, that they make every effort to tighten any loose financial ends that may exist.

About People

Administrators


Dwayne L. Hall

Dwayne L. Hall has been appointed business manager of the Children's Hospital of Philadelphia. Formerly administrator of the Bowling Green City Hospital at Bowling Green, Ky., Mr. Hall is a graduate of Denver University and received his master's degree in hospital administration from Northwestern University. He served his administrative residency at Louisville General Hospital and Waverly Hills Sanatorium, Waverly Hills, Ky., prior to assuming the administratorship of the Bowling Green City Hospital. He is a member of the American Hospital Association.

Wilson E. Tucker, administrator of Rochester General Hospital, Rochester, Pa., has been elected a member of the hospital's board of directors. With this change in position, his title has become executive director.

Dr. Lyman I. Thayer, superintendent of Westmount Tuberculosis Sanatorium, Glens Falls, N.Y., resigned September 1 to accept a position as assistant medical director of the District Three Tuberculosis Hospital at Paris, Ky. He succeeds **Dr. William H. Cloyd,** who has been appointed medical director and superintendent of the District Six State Hospital, Glasgow, Ky.

Sister Mary Eleanor, R.N., assistant administrator at St. Elizabeth Hospital, Elizabeth, N.J., has been transferred to St. Joseph Hospital, Paterson, N.J., where she will be assistant administrator.

Truman W. Yates has been appointed assistant administrator of Good Samaritan Hospital, Phoenix, Ariz. His administrative residency was served at the Latter-Day Saints Hospital, Salt Lake City, Utah. For the last two years he has been associated with Barnes Hospital, St. Louis, as assistant director; he has also been assistant director of the Washington University Clinics, St. Louis.

Eugene H. Barbera, who had been serving as administrative assistant at Children's Hospital, San Francisco, resigned that position to accept a position as business manager and assistant administrator of the Salinas Valley Memorial Hospital, Salinas, Calif. Previously Mr. Barbera served as administrative assistant at the St. Francis Hospital in San Francisco. He is a graduate of St. Louis University, having taken postgraduate work in hospital administration at the same university, and is a member of the American Hospital Association.

Nelson O. Lindley, assistant administrator of Beth Israel Hospital, Boston, has been named superintendent of Somerset Hospital, Somerville, Mass., and will begin his duties there early this fall.

Rose Jacobs, formerly of Hancock County Memorial Hospital, Greenfield, Ind., has been named administrator of Duke's-Miami County Memorial Hospital at Peru, Ind.


Graydon L. Andrews

Graydon L. Andrews became business manager of Peninsula Hospital, Burlingame, Calif., in July. He was formerly chief accountant of Merritt Hospital, Oakland, Calif., and business manager of Pittsburg Hospital in Pittsburg, Calif. He now serves as principal administrative assistant to the administrator and will coordinate all business activities of the hospital.

Charles R. Goulet has been appointed administrative assistant at Cleveland City Hospital following his administrative residency at Jefferson-Hillman Hospital, Birmingham, Ala. He is a graduate of the course in hospital administration at the University of Chicago.

Alice Villochi, superintendent of the Hospital for Crippled Children, Newark, N.J., has retired after 23 years of service there. She is being succeeded by **John R. Soyke** from the administrative staff of Graduate Hospital of the University of Pennsylvania, Philadelphia. Mr. Soyke is a graduate of New York University and has his master's degree in hospital adminsitration from Columbia University.


Frederic C. LeRocker

Frederic C. LeRocker took over the newly established position of associate general manager of Memorial Center for Cancer and Allied Diseases, New York City, on September 1. For the last two years, Mr. LeRocker has been assistant administrator of the San Jose Hospital, San Jose, Calif. He was administrative resident at Vancouver General Hospital and received the degree of master of hospital administration from the University of Minnesota.

Kenneth K. Atkins, formerly at Bethesda Hospital in Crookston, Minn., has been appointed assistant administrator at Northwestern Hospital, Minneapolis. He is a member of the American Hospital Association and a nominee of the A.C.H.A.

Arthur B. Allaben assumed his duties as assistant administrator of Ferguson-Droste-Ferguson Hospital, Grand Rapids, Mich. on July 1. He has been administrative resident at Wesley Memorial Hospital, Chicago, for the last year. His master's degree in hospital administration was received from Northwestern University.

Wilfred E. Stonebraker, personnel officer of the Veterans Administration Hospital, Omaha, Neb., became assistant manager of the V.A. Hospital, Iron Mountain, Mich., on July 20. Succeeding him is **Richard C. Knowlton,** who has held a similar position at the V.A. Hospital, Lincoln, Neb.


Edgar O. Mansfield

Edgar O. Mansfield has been named successor to **William Bashford Richards, D.D.,** superintendent of White Cross Hospital, Columbus, Ohio. Mr. Mansfield had held the position of associate in institutional services of the Board of Hospitals and Homes of the

(*Continued on Page* 176)

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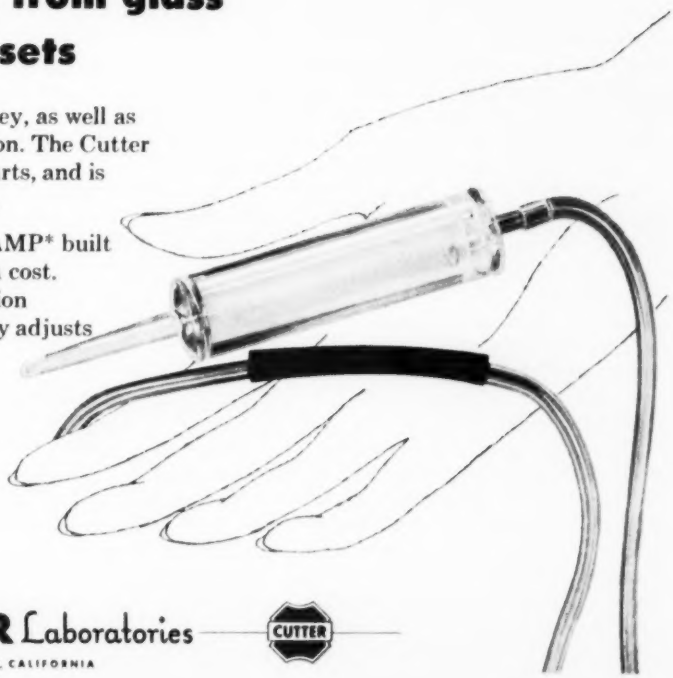

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Conducted by Raymond P. Sloan

This IS Social Service

MARY TOGNARELLI
Director, Medical Social Service Department
Bridgeport Hospital, Bridgeport, Conn.

ONCE upon a time, there was a Social Service Department—no different from any other Social Service Department, and like all Social Service Departments, its primary function was to try to help people—to help people who had lost in some measure their capacity to help themselves. Sometimes, this inability to go on was due to forces beyond the control of the individual, like illness or unemployment, and sometimes it was due to something deep down in the individual himself which prevented him from living a useful, happy life.

Thus, many and varied problems came to the attention of the Social Workers in this Department and, like many others before them they tried to mend the broken pieces and sometimes they just reenforced the crack a little, hoping that it might carry the load a bit longer. There were times when they were not successful at all, and when People on the Outside questioned their value; being discouraged, the Social Workers were inclined to question it, too.

But, let me tell you about the Lady-With-the-Cat. . . .

She was not a very young Lady. In fact, she had been receiving the "Old Age Pension" for some years. She had gray hair and eyes that could twinkle behind the sadness, but she was also a very sick Lady. And to make it worse, she had no one—no kith or kin—to call her own, except a cat, but an understanding, wholly-important-to-her, kind of cat, and when she was in pain and all alone in her third floor, two-room flat, the cat kept her company and seemed to need her, too, which made her feel better.

But one day the Doctor told her he could do no more for her on the outside, and that she must arrange to come into the hospital. But the Lady kept putting off "admission" because she could not leave her Understanding Cat.

The Social Worker, after talking with her, felt that perhaps behind her concern about her Cat, she was very afraid, afraid to admit that she was a very sick woman and that by coming into the hospital, she would be admitting the presence of a Dread Disease which, through the years, she had looked upon with Horror. But the Social Worker knew that she could not help the Lady until she, too, accepted the Lady's cat. She also knew that the Lady would be in the hospital for a long time, and that when she was discharged, she would need a period of Convalescence and Looking-After before she returned to her flat and her Cat.

And so she told her that she would try very hard to locate a place for her pet, to meet with the Lady's approval, and perhaps, then, the Lady would consider admission. There was much thinking-about-this on the part of the Lady, and the Social Worker was very busy for a while trying to find a suitable place. But, eventually, through Devious Ways, apparently known only to Social Workers, she located an Old Friend who had not been aware of the plight of the Lady, and *She* agreed to take the Cat. You can imagine how pleased this made the Lady, because not only had she found an adequate place for her pet, but there had been the Joy of Reunion with the Old Friend.

Hospitalization thus became easier for her to face because in addition to an Old Friend, she had a New Friend, the Social Worker, in whom she had begun to have confidence, with whom she could feel free, and whom she could respect. The Social Worker felt the same about her and thus was developed what is called in Social Work Parlance, Relationship, which is necessary in every helping process.

Needless to say, the Lady came into the hospital where she had a difficult time, believe me, but she never gave up hope. As the time for her discharge approached, she rebelled a little at the recommendation that she spend some time in a convalescent setting before returning to her flat. She had always been of an Independent turn of mind and it had been difficult for her to accept the "Old Age Pension" when she became too weak to hold a housework job. The necessity for the hospitalization seemed to point up her dependence, and referral to a Nursing Home seemed to emphasize it, too.

But, she was not a Foolish Woman, and during her stay in the hospital, she had been allowed to maintain her Integrity, and she had begun to understand that the service being offered her, its use and outcome, lay wholly within herself. And so, she went to a Nursing Home for a month, as the Doctors felt that this was all she would need. Since her rooms represented Warmth and Security and it was agreed that she could return there, the Social Worker was faced with the problem of what to do about keeping the rent paid, as the "Old Age" would pay for only the Nursing Home, where she could not stay indefinitely. The Old Friend interested an Organization made up of people of the Lady's national origin, and they assumed the small monthly rental because they, too, were aware of the Housing Shortage, and where would the Lady go when she left the Nursing Home if the flat were not kept for her?

She is back home now, resettled amongst the things that are her Very Own. The Old Friend and the Organization visit regularly. Her Condition has been carefully interpreted to the "Old Age," so that arrangements could be made for periodic checkups by a Doctor. And, of course, she has her Cat.

A "crack" that has been reenforced a little? The Social Workers like to think so.

Conducted by Robert F. Brown, M.D.

Case History of a Chest X-Ray Program

JOHN H. SERVIS
Assistant Director
Albany Hospital
Albany, N.Y.

SINCE April 1950, Albany Hospital, Albany, N.Y., has been participating in a program which is sponsored by the New York State Department of Health for the purpose of obtaining routine chest x-rays on all adult patients admitted to nonprofit general hospitals throughout the state. Any nonprofit hospital in the state may participate.

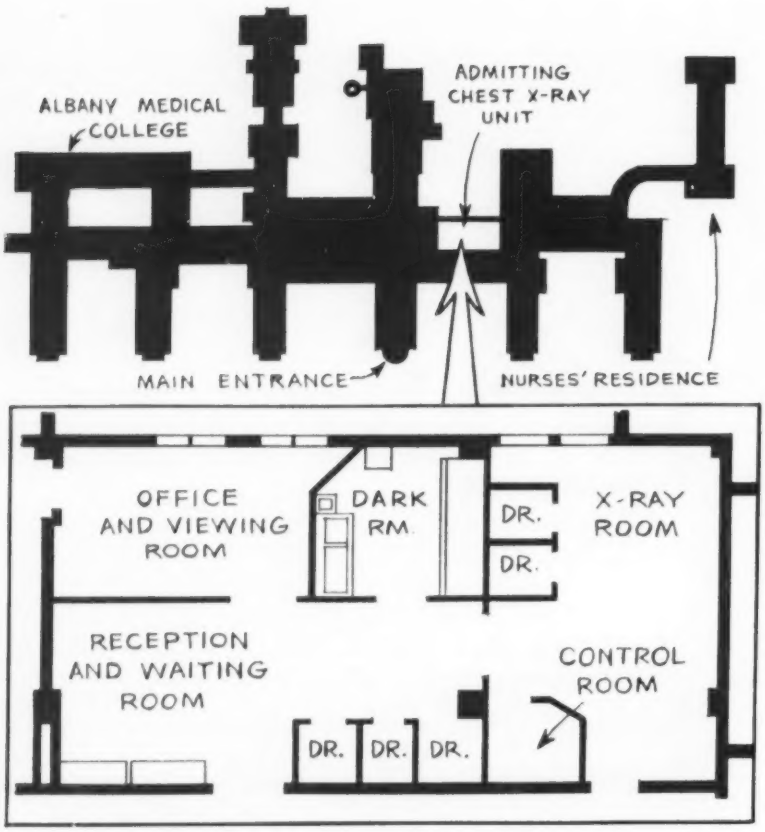
Hospitals that have a sufficient number of admissions to enable them to examine a minimum of 4000 adult patients annually are eligible for the loan of special x-ray equipment and to receive $0.50 for each x-ray report submitted to the local health department. For the purpose of this program, an adult is anyone 15 years of age or over. Hospitals that do not have the required number of admissions to qualify under this plan may participate by using their own equipment. Such hospitals receive $1 for each x-ray report submitted to the local health department. In return, the hospitals agree to make no charge to the patient for the initial examination or for any additional x-ray examination or interpretation necessary to establish a diagnosis of tuberculosis. They further agree to keep records and to submit reports as required by the state department of health. Furthermore, the hospitals agree to x-ray the chests of all employes not previously examined and of all new employes.

This program provides a simple but effective method by which the state can expand its search for new cases of tuberculosis. At the same time, the program benefits the participating hospitals by protecting its employes, patients and professional staffs from exposure to undiscovered cases of tuberculosis. Inasmuch as it had been the policy of Albany Hospital for many years to require chest x-rays on all new employes and to recheck employes at least once yearly, the examination of all patients being cared for in the hospital was a logical step in the expansion of its own program.

Patients who have been scheduled for admission through our reservations office are first interviewed in the business office where all the necessary data for admission are recorded. As a part of this procedure the interviewer writes the name, address and age of the patient on triplicate copies of form No. TB 44. These copies, together with the patient's chart cover containing his personal data are given to a messenger who takes the patient to the admitting x-ray unit. This unit is located only a short distance from the business office. A technician takes the x-ray film, stamps the face of the patient's chart to show that the x-ray was taken and returns the chart cover to the messenger, who then conducts the patient to his floor or ward. The technician retains the three copies of form No. TB 44.

The small 4 by 5 inch photofluorograms produced by the equipment in the admitting x-ray unit are developed and then read by the radiologists of our main x-ray department. The diagnosis is recorded on the three copies of TB 44. The original copy of this form is sent to the local health department for its files, the duplicate copy is filed permanently with the film in the admitting x-ray unit, and the triplicate copy is sent to the floor to be pasted in the patient's chart.

An x-ray technician at Albany Hospital displays a group of 4 by 5 inch photofluorograms used in the routine examination of patients.



White area on plan at top shows location of the admitting x-ray unit on the first floor of the hospital. Below: Enlarged diagram of x-ray unit.

Form No. TB 44 is supplied by the state of New York and contains the required diagnostic classification. At this point, we are mainly concerned with the provisional diagnosis which may be negative, suspected tuberculosis or questionable for some other condition. If the diagnosis is negative, nothing further is done once the report is pasted in the patient's chart. If the diagnosis is questionable for some condition other than tuberculosis this also appears in the patient's chart and it is the responsibility of the attending physician to order additional x-ray films if further study is indicated.

When the provisional diagnosis is suspected tuberculosis, the admitting x-ray unit promptly notifies the hospital tuberculosis service, the administrative office, and the nurse in charge of the patient's floor. This notice requires immediate isolation of the patient and a return of the patient to the main x-ray department for the large 14 by 17 inch chest plate. The nurse in charge of the patient's floor has authority to do this without having permission of the attending physician. In the meantime, the admitting x-ray unit has sent a requisition to the x-ray department ordering a 14 by 17 inch x-ray of the patient because of the questionable diagnosis. This larger film is read by the x-ray department staff and the diagnosis is reported to the admitting x-ray unit to be entered on the two copies it has of TB 44. The tuberculosis service and the administrative office are also notified and a written report of the diagnosis is pasted in the patient's chart. As a result of this further study, the tuberculosis service determines whether the patient is to remain on isolation, be taken off isolation, or be transferred to our contagious pavilion.

Thus far we have presented the ideal case in which the patient is a planned admission; he arrives at the hospital when the admitting x-ray unit is in operation, and he is able to be examined without discomfort. A good share of our admissions do occur in this way but there are others for which special arrangements have to be made. Accident cases and those that arrive after the admitting x-ray unit is closed have to be admitted without having an x-ray test. All such patients are brought to this unit on the day after admission or as soon after as the condition of the patient will permit. Each morning the admit-

Obverse (left) and reverse sides of form filed with state health department.

Form TB No. 44. 3-13-50-100M (9A-865)

NEW YORK STATE DEPARTMENT OF HEALTH
ROUTINE CHEST X-RAY REPORT
GENERAL HOSPITALS

Hospital ..... City .....
Patient's Name ..... (Last / First / Middle)
Home Address ..... (Street or RD No. / Town, Village or City)
Age ..... Sex ☐ M ☐ F | ☐ Inpatient ☐ Outpatient ☐ Employee
X-Ray Number ..... Date of X-Ray .....

PROVISIONAL DIAGNOSIS
☐ NEGATIVE

TUBERCULOSIS		OTHER CONDITIONS
1. Probably Active:	2. ☐ Probably Inactive	1. ☐ Card-vasc.
☐ Minimal	3. ☐ Suspect	2. ☐ Nonspec. Inf.
☐ Mod. Advanced	4. ☐ Pleural Effusion	3. ☐ Neoplasm
☐ Far Advanced		4. ☐ Fibrosis
		5. ☐ Other

Private Physician's Name .....
(Enter only if diagnosis is tuberculosis)

(THIS SIDE FOR HEALTH OFFICE ONLY)

Name .....
Home Address .....

FOLLOW-UP REPORT

DIAGNOSIS
Made by: ☐ TB hospital or clinic ☐ Private physician
Date
☐ Not Tuberculosis
☐ Active Tuberculosis
☐ Inactive Tuberculosis
☐ Suspected Tuberculosis

DISPOSITION
In TB Hospital ☐
At Home:
TB Clinic or PHN Supervision: Yes ☐ No ☐
Remarks:

a major development in intravenous anesthesia

SURITAL® SODIUM

(thiamylal sodium, Parke-Davis)

new ultrashort-acting intravenous anesthetic

SURITAL sodium—a distinctive advance in intravenous anesthesia—offers definite advantages to anesthesiologist, to surgeon, and to patient. Clinical experience in thousands of patients of from less than one year to more than ninety years of age has shown that **SURITAL** sodium...

provides more rapid induction
results in faster awakening

More detailed information on **SURITAL** sodium is available on request.

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SURITAL sodium is supplied as follows:

0.5-Gm. ampoule; also in combination package with a 20-cc. ampoule of Water for Injection. Individually and in packages of 25.

1.0-Gm. ampoule; also in combination package with a 50-cc. ampoule of Water for Injection. Individually and in packages of 25.

1.0-Gm. Steri-Vial® (rubber-diaphragm-capped vial); also in combination package with a 50-cc. ampoule of Water for Injection. Individually and in packages of 25.

5.0-Gm. ampoule without diluent. Individually and in packages of 25.

10.0-Gm. ampoule. Individually and in packages of 25.

Parke, Davis & Company
DETROIT, MICHIGAN

ting x-ray clerk checks the register of the previous day's admissions with her file of TB 44 forms and prepares a list of all patients admitted who were not examined. The name of each patient is carried from day to day until he has been returned to the admitting x-ray unit.

A considerable number of our maternity admissions are given x-ray tests before admission. The obstetricians on our staff ask their patients to come to the hospital some time during the six months' period prior to delivery for their chest x-ray and Rh tests. Clinic patients are sent by social service to the business office for interview and all procedures except actual admissions are completed. Should any cases of tuberculosis or suspected tuberculosis be discovered, proper follow-up can be made before admission.

Inasmuch as the purpose of this unit is to discover cases of tuberculosis, the equipment is not used exclusively for patients being admitted to the hospital. We have more than 30,000 visits to our clinic each year, and these patients comprise an excellent group for study. We are examining all new patients coming to clinic and, as rapidly as possible, all currently active clinic patients who have not had chest x-rays within the last year. Also, as we explained previously, all new employes are given an x-ray test as part of their preemployment physical examination, all student nurses are x-rayed on admission to the nursing school and periodically during their training, and all house doctors are examined when they arrive and at six month intervals thereafter. This means, then, that by careful adherence to this program, the possibility of spreading tuberculosis among patients and employes is considerably lessened, if not entirely eliminated.

During one year, 9368 chest x-ray films were taken in our admitting x-ray unit. Of these, 8570 were negative, 605 indicated some condition other than tuberculosis, and 193 indicated a possibility of tuberculosis. After further diagnosis, it was determined that 166 of these suspected cases were inactive and 27 had active tuberculosis. The discovery of these 27 active cases enabled the hospital to provide proper care for these patients and, at the same time, safeguarded the other patients, staff and employes who would have been exposed to tuberculosis had this procedure not been available.

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1. All Stainless Steel Construction.
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7. Sturdily constructed of heavy gauge Stainless Steel. Equipped with 4" ball-bearing casters and rubber cushioned bumpers on push handle for silent, smooth delivery to bedside.

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   C. The STERI-CART may be had without drawer assembly.
   D. Drawer Assembly of STERI-CART may be purchased separately at a later date. This unit takes only a few minutes to attach.
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CART SIZE: 18" x 33" x 33½"

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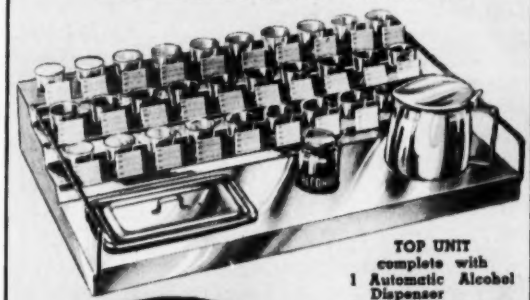

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30-1 oz. Med. Glasses
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Drawers illustrated show Syringes in carriers. Note medication wells under needles . . . confines dripage.

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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Differential Diagnosis and Treatment of

Migraine Headaches

FOR purposes of brevity, specific head pains, such as facial neuralgias, psychoneuroses (atypical pains), neck-muscle rigidity, earache and toothache, will be omitted from this review. While these pains occur in the head, they are usually due to a determinable cause and are relieved by specific measures rather than by drug treatment. Certain headaches accompanying such organic diseases as brain tumor and uremia will be included but not discussed, since in these instances the differential diagnosis is of paramount importance.

INTRACRANIAL PAIN RECEPTORS

The only sensitive structures inside the cranial vault are the basilar portions of the dura mater, tentorium, falx cerebri, and the blood vessels. The gray and white matter may be cut or cauterized without pain. The skin of the head may be completely anesthetized with procaine, and headache can still be induced. Ligation of the superficial arteries usually does not alter headache. Pain is localized to the deep arterial walls, dura mater, walls of the venous sinuses, and the supporting structures of the brain. The afferent impulses are carried over the fifth nerve for the anterior and middle meningeal arteries.

The posterior meningeal artery receives its nerve supply from the tenth and twelfth cranial nerves. Alcohol injections indicate that the fibers of the first division of the trigeminal nerve are chiefly concerned with the mediation of headache. Occasionally, however, the sensory nerve roots as low as the second or third cervical and all of the cervical sympathetic nerves must be severed to relieve intractable headache.

EXPERIMENTAL HEADACHES

Nitrite Headache. If 15 mgm. of glycerol trinitrate is rubbed on the skin, or 1 to 2 mgm. is applied sublingually, a headache that may last 24 hours will result in certain individuals. Tolerance is quickly established to this headache. The acute headache occurs after the blood pressure has recovered from the marked drop produced by the nitrites.

Histamine Headache (Pickering). If 0.1 mgm. of histamine is injected intravenously into any individual, a severe bilateral throbbing headache will appear in about two or three minutes and will last about five minutes. The headache does not occur during the drop in blood pressure accompanying the initial histamine shock. The pain can be definitely correlated with a rise in blood pressure above the initial level. If this is counteracted by continuous histamine infusion, the headache is prevented temporarily. Many physiological procedures, such as bilateral jugular compression, which affect the cranial blood supply and raise the cerebrospinal fluid pressure will relieve the headache. In the case of Horton's headache a subcutaneous injection of histamine produces the syndrome.

Caffeine-Withdrawal Headache. Many individuals will develop a headache if they do not obtain their morning cup of coffee. Making use of this observation, investigators learned that experimental headaches may be produced by giving subjects increasing doses of caffeine. Placebo capsules are then substituted on the fifth to seventh day of caffeine administration. The subject will feel depressed in the morning, and in the early afternoon a headache starts which reaches a maximum about 4 to 6 p.m. Nausea and vomiting may also occur with this type of headache. It is possible to induce this headache in 60 to 70 per cent of normal individuals. Ogden has found in analysis of a questionnaire answered by 4634 individuals that only 64.8 per cent of normal individuals are subject to headache.

Hypertensive Headache. If neosynephrin is given intramuscularly in doses of 5 to 10 mgm. to normal individuals, a severe headache will occasionally occur when the blood pressure is elevated. Ephedrine will also produce headache in overdosage. These headaches are perhaps strictly comparable to hypertensive headaches.

Carbon Monoxide Headache. The mechanism of this headache has been studied extensively by Swedish scientists and by Von Oettingen at the National Institutes of Health. A rise in CSF pressure has characteristically accompanied the headache and it appears that this is the only one of the experimental headaches which shows this phenomenon.

(*Continued on Page* 102)

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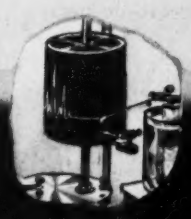

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Relaxation Headache. In subjects who are susceptible to this type of headache it is possible to reproduce it consistently by having them follow a daily cycle of increased activity and decreased sleep. The headache is then precipitated by having them sleep late. This may be the characteristic Sunday headache of the business executive or the postexamination headache of the student.

Fever Headache. Schumacher has found that with fever therapy the headache is accompanied by an increased excursion of the cerebral blood vessels. Many febrile diseases may have severe frontal headache as their initial symptom; of these the typhus group (rickettsial type) is the most important.

DIFFERENTIAL DIAGNOSIS

Definite Types

1. Eyestrain headache—frequently occipital or even nuchal. Relieved by adequate correction or rest. This is likely to be the cause of headaches which begin at 40 to 50 years of age.

2. Empyema of nasal sinus—usually accompanying a cold. Requires x-ray diagnosis to be accurate. Migraine and Horton's headache are frequently accompanied by a nasal discharge, which may confuse diagnosis. Migraine headaches are frequently termed "sinus headache" by the patient.

3. Brain tumor—morning headache (frontal or generalized) and change of posture intensifies. Sitting up in bed in a.m. may cause projectile vomiting.

4. Postspinal puncture headache—decreased CSF pressure. Horizontality is best treatment, does not respond to gynergen, but oxygen aids headache.

5. Hypertensive headache—worse in morning and disappears by noon (bursting headache). Treatment with "head-up bed" may be effective. Veratrum, or rauwolfia alkaloids, are sometimes very effective.

6. Migraine headache—twice as frequent in female. Unilateral, familial, scotomatous, periodic and accompanied by nausea and vomiting. Onset at puberty with relief at menopause—frequently with hypertension. Relieved by pregnancy, occurs frequently with menstrual period, occurs periodically with relaxation, frequently preceded by diuresis, 90 per cent respond to gynergen (ergotamine tartrate) or DHE-45 if given early in syndrome.

7. Horton's erythromelalgia — age 30 to 40. Sudden onset and relief, unilateral lacrimation and rhinitis, local vasodilatation. The syndrome can be produced by histamine and relieved by raising tolerance to histamine or by use of antihistamine drugs.

8. Posttraumatic headache—resulting from trauma following head injury without rest. Patient should stay with head up or head down after trauma. Spasm of the neck muscles may also be a factor in head injury.

9. Psychoneuroses—patient complains of pulling sensation, headache on top of head, tight band around head; also headaches are frequently associated with schizophrenia.

10. Toxic headache—carbon monoxide and lead poisoning, frontal headache of fevers. Nitrite poisoning, chronic tobacco poisoning.

11. Alcoholic hangover headache—varies with each individual but may be due in some instances to the marked changes in water balance that alcoholism induces.

12. Caffeine-withdrawal headache—as induced experimentally can be relieved with caffeine, benzedrine or oxygen therapy. This is probably the reason most proprietary medicines contain caffeine.

13. Relaxation headache—probably the cause of the Sunday headache in the business world, Monday headache of the clergy, and day-off headache of the nurse. May be due to peripheral relaxation of arterioles.

Indefinite Types

1. Hunger headache—going too long without food results in headaches that may or may not be relieved by eventual food intake.

2. Excess starch or sugar headache—corrected by diet containing mainly the vegetables that grow above the ground.

3. Food allergy headache—chocolate, onions, watermelon, cabbage, cucumber, garlic, green pepper, peanuts and possibly milk are the commonest offenders.

4. Hypotensive headache—orthostatic hypotensive syndrome. Fall in blood pressure on standing accompanied by syncope and headache. Treatment by "head-up bed."

5. Mountain or altitude sickness (as in aviators)—acute oxygen want.

6. Headache caused by unaccustomed exposure to a bright sun—may be a relaxation type of headache with peripheral vasodilatation.

7. Headache accompanying epilepsy, eclampsia, bleeding peptic ulcers,

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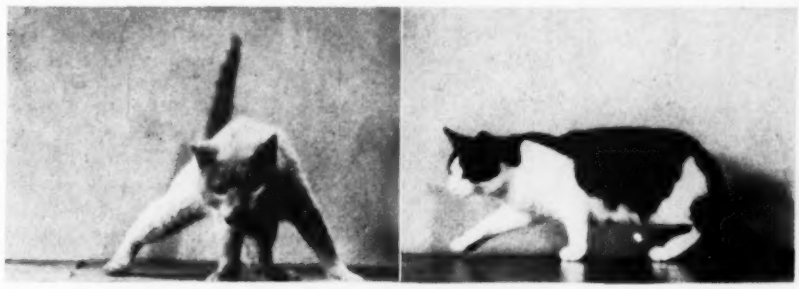
The hazard of ototoxicity is greatly reduced by combining equal parts of streptomycin sulfate and dihydrostreptomycin sulfate. The patient thus gets only *half* as much of each drug. The risk of vestibular damage (from streptomycin) and of hearing loss (from dihydrostreptomycin) is greatly reduced. Therapeutic effect is undiminished. This principle has been demonstrated in both animals and man. In patients treated for 120 days with 1 Gm. per day of the combined drugs, the incidence of neurotoxicity was practically zero.



Cat treated with streptomycin is ataxic.

Cat treated with the same amount of streptomycin-dihydrostreptomycin has normal equilibrium.

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	DISTRYCIN	DICRYSTICIN	DICRYSTICIN FORTIS	DISTRYCILLIN A. S.
Streptomycin sulfate, Gm.	0.5	0.25	0.5	0.25
Dihydrostreptomycin sulfate, Gm.	0.5	0.25	0.5	0.25
Procaine penicillin G, units	—	300,000	300,000	400,000
Potassium penicillin G, units	—	100,000	100,000	—
	(All supplied in 1 and 5 dose vials)			

SQUIBB
a leader in the research and manufacture of penicillin and streptomycin

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Addison's asthenia, cerebral syphilis, and myxedema.

MECHANISM OF MIGRAINE

Lauter Brunton suggested near the close of the Nineteenth Century that the cerebral blood vessels must be involved in migraine headache inasmuch as he was able to obtain relief of his unilateral headache by carotid pressure. Ray, Graham and Wolff in 1937 demonstrated adequately that the headache is associated with an increased excursion of the cerebral blood vessels, and when the headache is relieved by ergotamine tartrate the excursion of the blood vessels decreases.

Theoretically, an increased excursion of the cranial blood vessels could result from an increased arterial blood volume, decreased blood volume, increased blood pressure, decreased blood pressure, increased cerebrospinal fluid pressure, and finally a decreased cerebrospinal fluid pressure. Most migraine headaches are perhaps accompanied by a decreased blood volume with a relaxed peripheral vascular tone. Therapy should, hence, be directed at increasing the peripheral vascular tone (ergotamine tartrate) or increasing the blood volume (salt mixtures or hypertonic I.V. solutions).

THERAPY OF ACUTE MIGRAINE

The ascribed etiology and resultant therapy of migraine and most recurrent headaches depend on the specialist consulted. The endocrinologist is likely to ascribe much of migraine to endocrine deficiency; the allergist claims a high percentage of these cases when he diagnoses the condition, and the psychiatrist is likely to apply psychotherapy for all types of headache. In most cases the interested general practitioner or neurologist achieves the best subdivision of the migraine syndrome so that the patient obtains the proper therapy for his particular case.

Ergotamine Tartrate or Dihydroergotamine (DHE-45). Either 0.3 cc. intravenously, or 0.5 cc. to 1.0 cc. of 1-2000 gynergen intramuscularly, if given at the onset of an attack, will result in relief in one to two hours in 90 per cent of the patients (use twice as much with DHE-45). Atrophine 0.5 mgm. may aid nausea and vomiting produced by gynergen, and calcium gluconate (10 cc. of 10 per cent) may relieve the muscle cramps produced by gynergen. If oral treatment (which is not nearly as effective) is attempted, the 1 mgm. tablets should be placed under the tongue until completely dissolved. This may be repeated once or twice in 24 hours without danger of poisoning. If 2.5 to 10 mgm. of benzedrine sulfate or 100 mgm. of caffeine (Horton) is combined with the oral dose, more effective relief is obtained, possibly because of synergism in the peripheral vasoconstricting action.

Analgesic Prescription (Proprietary Type)

Acetphenetidin	2	0
Acetylsalicylic acid	4	0
Caffeine citrate	1	2
*(Codeine phosphate)	0	8

Put in capsules No. 24.
Sig. Take one or two capsules at first sign of headache.
*May be added depending on severity of attacks.

Oxygen Therapy. From 6 to 8 liters per minute flowing 100 per cent through a Boothby or nasal mask may abort an acute attack if taken early enough.

Antihistamine Therapy. Some migraine patients receive marked relief of their syndrome after benedryl or pyribenzamine therapy. A few can be relieved by means of parenteral papa-

verine therapy (60 mgm. intravenously).

Sodium Nicotinate. This may relieve the migraine syndrome in selected cases. Goldzieher and Popkin claim 75 per cent effectiveness with 100 mgm. injected intravenously.

Octin. From 100 to 200 mgm. of octin, given subcutaneously, is also credited with relief of the acute migraine syndrome.

Barbiturates. These may be effective in producing sleep in spite of the migraine syndrome, and the patient may be free of the attack when he awakens.

SUPPORTIVE THERAPY TO PREVENT MIGRAINE ATTACKS

Thyroid Therapy. Even with a normal basal metabolism rate, migraine patients are frequently relieved by thyroid therapy. Adequate tests must be made from time to time to avoid thyroid overdosage.

Calcium Gluconate or Lactate—3 teaspoons daily. Particularly useful in patients who show a decreased serum calcium and elevated serum phosphorus.

Calcium Lactate—KCl Therapy. Same proportion of these ions as is present in the blood serum based on the theory that this proportion is necessary to increase the blood volume. Gr.X of mixture taken T.I.D. after meals. Mixture consists of 308 Gms. of calcium lactate to 225 Gms. of potassium chloride. Sixty per cent success in treatment of migraine with this mixture. While it is better as supportive treatment, it may also be used in acute attacks.

Diet Therapy. The best dietary treatment has been found empirically to consist of a low carbohydrate diet.

Histamine Infusion to Raise Tolerance. Since histamine is a pure chemical, patients are not desensitized to histamine but do have their tolerance raised to its pharmacodynamic effects. While this is used extensively, we do not as yet have controlled studies on its effectiveness.

Menstrual Migraine. This can sometimes be prevented by either ammonium chloride therapy started 10 days prior to menstruation or progesterone and estrogen therapy started three to four days before the onset of the menses.

Phenobarbital. In sedative doses phenobarbital or mephenesin may be effective in those patients whose attacks occur when they become unduly excited.—C. C. Pfeiffer, Ph.D., M.D.

Conducted by Mary P. Huddleson

What Good Is a Dietary Consultant?

Indiana hospitals find that the state consultant helps raise standards and solves problems arising in such areas as meal planning, kitchen design and personnel

MARIAN C. JONES
Formerly, Institution Nutrition Consultant
Indiana State Board of Health
Indianapolis

DIETARY consultation service provided by the state was a new approach for Indiana when the nutrition service of the state board of health early in 1948 added to its staff an institution nutrition consultant. The need for such a service was emphasized after the first hospital licensing surveys were made by the division of hospital and institutional services. (This division has the responsibility for licensing all general and allied special hospitals.)

Basically, the activities of the institution nutrition consultant may be classified in four major areas: hospital licensing and consulting activities, planning new hospital dietary facilities, consulting services to child care institutions, and some consultation service for the county homes for the aged. Only the first two activities will be considered here.

The work of the institution nutrition consultant has a direct relationship to several other fields of professional interest and is coordinated with allied personnel of the state board of health. The physician, hospital administrator, nurse, sanitary engineer and food sanitarian share the responsibility in the licensing, planning and consultation phases of the work.

The activities related to the hospital licensing program deal primarily with conducting surveys of the hospitals to determine the degree of their compliance with "General Regulations for Hospitals," the standards used in administration of the licensure program. The dietary regulations included in the general regulations cover supervision of the department, establishment of written policies and procedures, and nutrition standards for feeding patients and personnel. Other regulations pertain to the sanitation of the dietary department, which is surveyed by engineers and food sanitarians.

The first step taken by the consultant was to survey all hospitals in Indiana. The visits were made at meal periods so that a complete study could be made of the final food preparation, food service to both patients and personnel, and the cleaning up processes. For future use in consultation service a comprehensive form was prepared covering the department supervision, number of patients served, facilities, use of the facilities, policies and procedures, menu planning procedures, nutrition standards, planning for modified diets, and formula room procedures if they were under the dietary department.

During this phase of the program, establishing rapport with the hospital personnel was important. When the visits were made, the plan for visiting the dietary department was arranged with the hospital administrator. Often, if there were problems within the department, they were discussed at this time. When the survey was completed, if the administrator had not been present, the findings were discussed with him and recommendations were made.

After the initial surveys were made an in-service training program was provided for the four consultant nurses and the hospital administrative consultant in the division of hospital and institutional services, since they are responsible for surveying hospitals in their entirety. The dietary section of the complete survey report was then studied and rewritten so that representatives from that division could fill out the dietary section in future surveys. Since then, surveys have been made only in hospitals in which the consultant nurses found problems needing dietary assistance and in those where the administrator of the hospital requested that a dietary survey be made by the institution nutrition consultant. However, in hospitals where the dietary departments were surveyed by the consultant nurses or the hospital administrative consultant, these people brought back menus for evaluation.

In the "General Regulations for Hospitals," the section on the supervision of the dietary department states that if the hospital does not have a qualified dietitian it shall receive pe-

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There is no better complement to your buffet service than Sexton conserves, preserves and jellies. Their superb flavor is quickly recognized by the discriminating guest—and remembered. The secret is simple—just fresh, ripe fruit, cooked slowly, in small batches. At luxury hostelries or the most modest eating places, they more than pay their way.

A seasonal reminder. Now ready, this season's supply of Sexton's Old English Mince Meat—aged in the wood since spring. Order now to make sure of your share!

JOHN SEXTON & CO., CHICAGO. 1953

riodic consultation from a qualified person in the community or from the nutrition consultant of the state board of health. Recently, 15 hospitals have been receiving this consultation from the state board of health. In these hospitals more emphasis has been placed on menu planning and modified diets than on other phases of the dietary department. At first, much time was spent with the persons responsible for planning menus—in teaching them how to plan their own menus, both regular and soft, using the facilities, personnel and food available. Later on, they were provided with sample check lists so they could evaluate their own menus. In this group of hospitals, the menu planning was done by various people: kitchen managers, cooks, matrons, nurses, technicians and administrators.

After the preliminary work, each hospital sent to our office a week's menu for regular and soft diets. These were evaluated and the hospital administrator was advised if changes were recommended. If the menus were inadequate, a return visit was made and the menu planning principles were reviewed with the responsible person.

ASSIST IN SEVERAL AREAS

These hospitals are now visited four or five times a year. On such visits, assistance is given in areas other than menu planning. For example, they are shown how to establish dietary policies and procedures for better organization of the dietary department. A suggested guide for dietary policies and procedures was developed. They were given some standardized recipes and encouraged to develop their own recipe files. Recipe books suitable to the size of the hospital were suggested.

Although the sanitation of the dietary facilities is checked by the engineers and food sanitarians, the institution nutrition consultant assists the hospitals in making proper use of their facilities and accepted food handling procedures. The suggestions most frequently made were concerned with use of dishwashing facilities, *i.e.* proper loading of dish trays, dismantling of the machine for cleaning, and, when necessary, correct use of hand dishwashing facilities for proper sanitation. A booklet on procedures for hand dishwashing to achieve the minimum requirements established by the state board of health was developed and has been used extensively in all institutions.

Modified diets in the smaller hospitals do not seem to be as much of a problem because most of them have very few such diets. However, assistance has been given in finding and using up-to-date diet manuals that would be suitable for the dietary personnel to follow. The use of the "Diabetic Meal Planning With Exchange Lists" was explained in all hospitals visited.

As this program of assistance developed, requests for assistance in solving various problems came from institutions other than those receiving regular consultant service. On occasions we were able to assist hospitals in finding dietitians.

As a result of the effort made by the hospitals to improve their dietary supervision over the past several years, the following has been noted:

1949 Findings	
Hospitals with A.D.A. dietitians on the staff	25.8%
Hospitals with home economic graduates on the staff	7.2%
Total	33.0%

1952 Findings	
Hospitals with A.D.A. dietitians on the staff	31.2%
Hospitals with A.D.A. dietitians giving regular consultation	13.7%
Hospitals with home economics graduates on the staff	12.2%
Total	57.1%

Also, 19.8 per cent of the hospitals now have kitchen managers in charge of their dietary departments as compared to 8.8 per cent in 1949. Most of these kitchen managers have had some food experience either in restaurants or in school lunch programs.

The areas in which assistance has been given have been varied. One of the most frequent requests has been for help in revamping patient and personnel food service methods. Often, where a central tray service system was in effect and the patients were complaining of hot food received cold, a combination of central and decentral tray service was planned. In a few instances, where nursing department personnel was spending time serving trays, plans were worked out for the dietary personnel to take over this function to relieve nursing personnel for nursing duties.

Several hospitals, in line with present trends, have changed their personnel food service from table to cafeteria service and assistance has been given in planning for this, both in equipment needed and procedures to be used. Where the cafeterias were to be on a cash basis, they were shown how to figure food costs on items served.

Assistance has also been given in developing food cost controls, in interpreting dietary regulations, in changing employes from split to straight shifts, without employing too much additional personnel, and in determining the number of employes necessary to accomplish dietary functions. Questions on various food laws have been answered for dietitians.

USE TEACHING FILMS

In visits to the hospitals, physicians have been contacted to review the modern trends in diet therapy. The slide films showing the use of the "Meal Planning With Exchange Lists" for diabetics have been shown to classes of student nurses. Occasionally, the modern trends in teaching dietetics to student nurses have been discussed with dietitians and nurses.

During the last year and a half, four dietary refresher conferences were held in various sections of Indiana. The first was held in the northeastern section of the state. In this area there are quite a few small hospitals. The planning committee consisted of a dietitian in the area, a member of the hospital staff, and a state board of health nutritionist. The conference was held in a central location for the convenience of those attending. The hospital administrators were invited to attend and bring the persons in charge of their dietary departments.

The areas covered in the program were (1) general sanitation, (2) menu planning and (3) the use of modified diets. In subsequent visits to the hospitals which had sent representatives, there was evidence that they were using the information gained at the meeting.

In other areas of the state, a different plan was worked out as most of the hospitals were farther apart. The next three meetings were held in conjunc-

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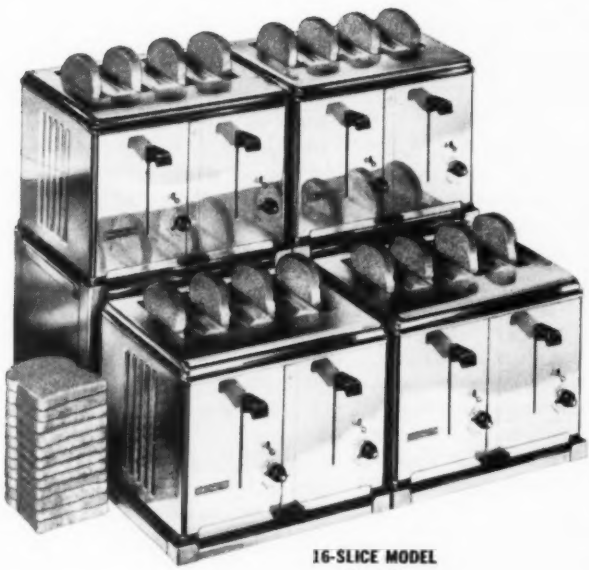
$99.50†

No matter how many patients you serve there's a "Toastmaster" Toaster to suit your needs. The 16-slice model pops up 1000 slices per hour; the 4-slice, 250; and there are three sizes in between. This capacity helps you serve patients in less time, and therefore at lower cost.

Plenty of toasting capacity ...and every slice perfect!



16-SLICE MODEL
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You're sure of perfect toast with the "Toastmaster" Toaster. Every slice pops up golden brown and delicious. And every slice reaches patients hot, fresh and crisp. That's because "Toastmaster" Toasters fit wherever you need them—in the main kitchen and in your floor diet kitchens. Toast for each floor is made *on that floor*.

You'll like the way this completely automatic toaster frees help for other duties—the ease with which it makes light, dark or in-between toast. Your hospital personnel will appreciate the steps it saves, its sturdy construction, and easy cleaning features.

Saves your hospital money, today and tomorrow too! Buy only the size you need today, then add 2-slice or 4-slice units as your toast needs increase. This assures you up-to-date capacity, without tieing up money in idle toasters.

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ings. The presidents of the councils were contacted first and each council voted to have the dietary refresher conference and set the dates and meeting places. The same pattern for the program that was used at the first dietary refresher conference was followed.

Long-range plans of the nutrition service of the state board of health include coverage of the entire state with dietary refresher conferences.

The activities in the planning for new hospital facilities under the Hill-Burton Act have included reviewing of plans and specifications and assisting in the preparation of equipment lists for dietary departments.

The architect who has been selected to prepare drawings first submits schematic plans. These are checked for functional arrangement in relation to the other hospital departments. Following the review of these plans, a meeting is attended at which the suggestions are reviewed with the architect and local hospital board.

The architect then submits a preliminary set of plans and these include placement of equipment. These are reviewed for functional flow of work through the dietary department, for equipment provided, and to check the proposed facilities for compliance with the hospital licensing regulations in the provision of toilet and handwashing facilities. The recommendations on these plans are also reviewed with the architect and local hospital board. Often, the kitchen detail has been worked out with the person designated by the architect to do the kitchen planning.

After preliminary plans have been revised and approved, the architect goes ahead with the final blueprints and specifications which map out the construction details and give the specifications for the built-in equipment to be provided. When these are submitted, they are reviewed very carefully to see that all essential equipment is provided and properly placed. The kitchen equipment specifications are read in detail to be sure the size of the equipment is correct in relation to the size hospital and that all equipment is provided, *i.e.* racks for the dishwashing machines, pans for cafeteria counters, and so on. If they are not included in the specifications, they must be included later in the movable equipment list.

While the hospital is under construction, planning for the movable equipment goes ahead. This is done by the administrator of the hospital who has usually been appointed by this time. He is assisted in preparing the lists and a final check is made before they are submitted to the U. S. Public Health Service regional office to be certain everything needed has been included.

Assistance has been given, on request, to existing hospitals which have remodeled their dietary departments. In such cases, meetings with the hospital administrator, architect, and sometimes the hospital board members and county commissioners are arranged to discuss their existing facilities and needed changes. If the hospital has a dietitian she is included in the meeting. From the agreements reached at these meetings, the architect proceeds with drawings for the remodeling. After the plans are drawn up, they are reviewed again if a request is made for this.

One of the hospitals for which this assistance was given was a 100 bed hospital which had a kitchen manager but no qualified dietitian. The remodeling plans included an addition to the existing dietary area and resulted in a much more functional unit with adequate equipment to serve all the patients. However, the new facility necessitated a change in food service for both patients and personnel. Several visits were made to help the hospital work out plans for changing from a central tray service to a combination of centralized and decentralized service. The new service is conducted throughout by dietary employes and has resulted in better patient food service. The personnel service was changed from table service to a cash cafeteria and some assistance was given in this area.

During the years in which the dietary consultant work in this state has been progressing, materials have been developed. Several have been mentioned, such as the menu check list, the outline of suggested dietary policies and procedures, and the pamphlet on dishwashing. We have also made up lists of menu suggestions and tray setups. A bibliography of available materials has been prepared and is revised periodically. It includes the names of recipe books and other books to assist in dietary administration, and a list of available posters and pamphlets. For our own use, we developed a comprehensive survey form to review hospital dietary departments and a check list for reviewing blueprints.

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CREVICE-FREE CONSTRUCTION

- ***protects insulation and electrical parts***
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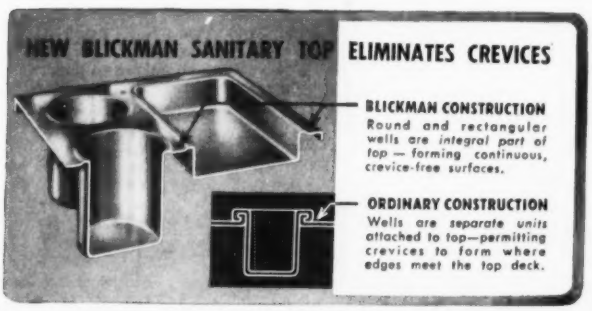
To maintain the immaculate, sanitary surfaces of your Blickman-Built food conveyor, you cut grease and dirt with live steam — then wash with hot water. Cleaning is quick — simple — thorough. Water can't seep into the insulation or electrical elements when cleaning instructions are followed. *The reason*: Blickman conveyors have one-piece seamless tops and bodies of highly-polished, electrically-welded stainless steel. There are no joints, crevices, screws, bolts, or rivets to trap dirt or furnish breeding places for vermin. That's why Blickman conveyors cost little to maintain and assure long, trouble-free service. Blickman food conveyors are built for cleanliness and durability. They belong in your institution.



Model ALS-4922

New **SELECTIVE MENU CONVEYOR**

• One conveyor now gives you a great variety of inset arrangements for your selective menus. Interchangeable square and rectangular pans can be placed in the rectangular wells in different combinations. Round wells are used for soup or other liquids; two heated drawers for special diets. Built with sanitary seamless top and one-piece crevice-free body.

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FOOD SERVICE EQUIPMENT

See the Catalog of Blickman-Built Food Conveyors in the Hospital Purchasing File

FOOD FOR THOUGHT

How Long Will It Keep?

"How long will foods keep good quality in a refrigerator?" There can be no fixed answer, because the keeping quality of a perishable depends on its condition and the temperature and humidity of the refrigerator. However, through wrapping foods correctly and keeping them at the right temperature it is possible to predict roughly a food's probable storage life.

In an automatic refrigerator with the control set for normal operation, the center storage section of the cabinet will probably run between 38° F. and 42° F. The area just below the freezing unit is colder for storage of foods, such as meats, poultry and fish, needing the lower temperatures. The bottom of the cabinet is somewhat warmer than the center for less perishable foods. If in doubt about your refrigerator, take the temperature in different locations with a thermometer. Any refrigerated food that tends to become unpalatable through drying or shriveling should be kept covered.

U.S.D.A. food technologists have outlined the following table, showing storage conditions needed, and how long food is likely to hold good quality if it is fresh when refrigerated.

FOOD	STORAGE TO HOLD GOOD QUALITY
Milk	Keep below 45° F. Use within three days for best quality.
Eggs	Keep at 42° F. Use within seven days for best quality. Probable storage life, two to six weeks.
Hard cheese	Keep tightly wrapped or in closed container. Surface mold may be trimmed off. May keep for months.
Soft cheese	Keep in closed container in coldest part of refrigerator. Will keep approximately one to two weeks.
Fresh meat: fresh meat cuts, ground meat, liver, variety meats	Store loosely wrapped at 38° F. Storage time for pork cuts somewhat shorter than for other meat cuts. Use ground meat in one day, variety meats in two, fresh meat cuts in three to six days.
cold cuts, sliced	Wrap in semi-moisture proof material, such as waxed paper, and store at 38° F. Use within six days for best quality.
Cured meat: bacon, sliced	Store at 38° F. Use within seven days for best quality. Probable storage life, three to four weeks.
ham, tender cured	Store at 38° F. Use half ham within seven days for best quality; whole ham within 10 days. Probable storage life of whole ham, six weeks; of half ham, three to four weeks.
tongue, smoked	Store at 38° F. From five to seven weeks.
dried beef, sliced	Store at 38° F. Four to six weeks.
corned beef	Store at 38° F. Use within six days.
Poultry	Remove from tight wrappings, wrap loosely. Store at 35° F. Use within two or three days.
Fresh fish	Store loosely wrapped at 32° F. Use within one day for quality.

Thrive on hard usage
...breakage low
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that's why the University of Michigan South Quadrangle Residence Hall standardized on Libbey Heat-Treated Tumblers in feeding its 1200 students

MANY of the country's largest hotels, restaurants, hospitals and schools send the same report: Libbey Heat-Treated Tumblers can take heavy "punishment" —that's because they're specially processed to stand up 3-5 times longer than ordinary tumblers.

For added safety, every Libbey glass has a chip-resistant rim . . . at the spot where most glassware chips first! This feature means added economy through reduced breakage, smaller needed inventory and fewer glassware replacements. And every Libbey glass has the additional money-saving protection of this famous guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips!"

Why not see how Heat-Treated Tumblers can cut your glassware costs and at the same time give you a better glassware service? Your Libbey supply dealer has samples and prices of the full line. See him or write direct to Libbey Glass, Toledo 1, Ohio.

This recently completed University of Michigan South Quadrangle Residence Hall was built at a cost of well over 5½ million dollars. It is recognized as one of the most modern dormitories in the country. 1200 students live here according to the Michigan House Plan which divides the Quadrangle into seven house groups and four dining rooms.

LIBBEY GLASS *Bounce Tumblers*

ESTABLISHED 1818

Libbey HEAT-TREATED

LIBBEY GLASS, Division of Owens-Illinois Glass Company, Toledo 1, Ohio

Menus for October 1953

Elizabeth Halleck
Chief Dietitian
Greenwich Hospital
Greenwich, Conn.

1 Grapefruit Half Poached Egg, Bacon • Roast Loin of Pork Cinnamon Apple Franconia Potato Fresh Chopped Spinach Red Cabbage, Apple and Raisin Salad Toasted Coconut Layer Cake • Consommé With Julienne Vegetables Spaghetti Creole Romaine, French Dressing Baked Fresh Pear Whipped Cream	**2** Tomato Juice Scrambled Eggs • Seafood Supreme Steamed Snowy Rice Broccoli, Lemon Wedge Chef's Salad, Creole Dressing Strawberry Chiffon Pie • New England Clam Chowder Sliced Hard Cooked Egg 1000 Island Dressing Potato Salad Lime Soufflé Salad Peach Halves Oatmeal Cookie	**3** Blended Juice Soft Cooked Egg, Muffin • Baked Virginia Ham With Raisin Sauce Candied Yams Baby Lima Beans Sunshine Salad Mayonnaise Lady Baltimore Cake • Homemade Vegetable Soup Baked Beans, Salt Pork Brown Bread Lettuce Wedge Chiffonade Dressing Half Grapefruit Refrigerator Cookie	**4** Orange Juice Griddle Cakes, Sirup • Half Broiled Chicken Potatoes au Gratin Brussels Sprouts Cranberry Salad Mold Chocolate Chip Ice Cream Angel Cake • Tomato Rice Soup Creamed Dried Beef on Split Baked Potato Garden Peas Celery Hearts, Carrot Curls Rainbow Frosted Spice Cup Cake	**5** Stewed Prunes Fried Egg, Bacon • Roast Sirloin of Beef au Jus Whipped Potatoes Fried Eggplant Mixed Vegetable Salad Apple Pie • French Onion Soup Individual Casserole of Tuna Fish French String Beans Romaine, Russian Dressing Stewed Plums Molasses Cookie	**6** Pineapple Juice French Toast, Sirup • Breaded Veal Cutlet Tomato Sauce Escalloped Potatoes Baked Hubbard Squash Head Lettuce With French Dressing Brownie • Split Pea Soup American Chop Suey Wax Beans Marinated Diced Cucumber Salad Tokay Grapes
7 Orange Half Soft Cooked Egg, Sausage • Roast Leg Lamb With Mint Sauce Baked Idaho Potato Asparagus Spears Cabbage Salad Cherry Tart • Essence of Celery Soup Grilled Bacon Individual Baked Sweet Potatoes and Apples Chef's Salad, With Piquant Dressing Frozen Pineapple Chunks	**8** Grapefruit Juice Poached Egg, Bacon • Turkey à la King Hot Biscuit Steamed Brown Rice Buttered Peas Applesauce Cake With Orange Frosting • Scotch Broth Hot Meat Sandwich Fresh Sliced Carrots Sweet Pickles Stuffed Apricot and Cream Cheese Salad Royal Anne Cherries Sugar Cookie	**9** Prune Juice Scrambled Eggs, Muffin • Spanish Omelet French Fried Potatoes Ford Hook Lima Beans Celery Hearts Devil's Food Layer Cake • Oyster Stew With Oyster Crackers Stuffed Peppers (Macaroni, Tomatoes, Cheese) Cottage Cheese and Crab Apple Salad Baked Lemon Sponge	**10** Apple Juice Brown Sugar Coffee Cake • Roast Fresh Ham Horseradish Sauce Whipped Sweet Potatoes Escalloped Tomatoes Autumn Salad Tinted Éclair • Chicken Broth Grilled Sausages French Toast, Maple Sirup Waldorf Salad Baked Cup Custard	**11** Grapefruit Half Waffles, Sirup • Roast Ribs of Beef au Jus Mashed Potatoes Diced Yellow Turnips Chef's Salad Pineapple Ice Cream Brown Edge Wafer • Cream of Asparagus Soup Chicken-Vegetable Salad Deviled Egg and Cress Salad Emerald Island	**12** Sliced Banana Egg, Bacon • Individual Chicken Pie Sliced Tomatoes Fresh Fruit Cup Almond Cookie • Cream of Mushroom Soup Beef Hash French String Beans Ambrosia Salad Pink and White Cake
13 Stewed Prunes Poached Egg Toast, Bacon • Sauté Liver Rasher Bacon Creamed Diced Potatoes French Fried Onions Dream Bar • Beef Consommé Casserole Escalloped Ham, Eggs and Mushrooms Pear and Shredded American Cheese Salad Peach Upside-Down Cake	**14** Grapefruit Sections Bacon, Raisin Toast • Grilled Hamburger Hot Roll Home Fried Potatoes Succotash Radishes Lemon Chiffon Pie • Cream of Chicken Soup Sausage Apple Fritters With Maple Sirup Mixed Green Salad Celery Seed Dressing Whole Peeled Apricots Macaroon	**15** Tomato Juice Canadian Bacon and Egg • Stuffed Pork Chop Macaroni and Cheese Glazed Carrot Strips Celery Hearts Boston Cream Pie • Jackson Soup Club Sandwich Stuffed Olives Fruit Compote Petite Cup Cake	**16** Blended Juice Toasted English Muffin • Escalloped Oysters Whipped Potatoes Garden Peas, Carrot Sticks Apple Turnover • Manhattan Clam Chowder Salmon Loaf With Pea and Mushroom Cream Sauce Chopped Spinach Pineapple and Paprika Cottage Cheese Salad Bananas Sliced in Orange Juice	**17** Prune Juice Egg, Bacon • Pot Roast of Beef Baked Fine Noodles Mexican Corn Chow Chow Mint Frosted Devil's Food Layer Cake • Cream of Celery Soup Rolled Ham Swiss Cheese Hot Potato Salad Radish Roses Cinnamon Applesauce Molasses Cookie	**18** Orange Half Griddle Cakes, Sirup • Roast Turkey With Bread Stuffing Cranberry Sauce Candied Sweet Potatoes Cauliflower au Gratin Maple Nut Ice Cream Pinwheel Cookies • Chicken Noodle Soup Rasher Bacon Welsh Rabbit Grilled Tomato Fresh Fruit Salad, Harlequin Dressing Black Bing Cherries
19 Stewed Prunes Orange Bun, Sausage • Roast Leg Lamb With Mint Jelly Parsley Buttered Potato Baby Lima Beans Asparagus Spears Gingerbread, Foamy Sauce • Essence of Turkey Soup Grilled Canadian Bacon Macaroni and Cheese Carrot and Apple Salad Apricot Halves Date Bar	**20** Applesauce Soft Cooked Egg, Bacon • Beef Stew Whipped Potatoes Breaded Parsnips Stuffed Celery Hearts Frosted Marble Cake • Washington Chowder Ham Loaf, Sauce Buttered Green Peas Head Lettuce With Roquefort Cheese Dressing Rhubarb and Strawberries	**21** Grapefruit Half Poached Egg, Toast • Roast Sirloin Beef Rhode Island Potatoes Baked White Onions Carrot Curls Banana Cream Pie • Barley Soup Baked Zucchini Casserole (Tomatoes and Cheese) French String Beans Ripe Olives Pear Halves Pecan Lace Cookies	**22** Pineapple Juice Scrambled Eggs, Bacon • Meat Loaf, Gravy Oven Brown Potatoes Whipped Turnips Assorted Relishes Coconut Frosted Gold Cake • Beef Vegetable Soup Grilled Bacon Spanish Rice Green Salad With 1000 Island Dressing Baked Apple, Cream	**23** Orange Juice Egg, Clover Leaf Roll • Vegetable Plate French Fried Cauliflower Stuffed Baked Potato Grilled Tomato Half Deviled Egg Salad Blueberry Pie • White Bean Soup Tuna Loaf, Mayonnaise and Potato Chips Asparagus and Pimiento Salad, Mayonnaise Orange Tapioca Pudding	**24** Apple Juice Brown Sugar Coffee Cake • Braised Ribs of Beef Whipped Potatoes Broccoli, Hollandaise Sauce Dill Pickles Burnt Sugar Cake • Bouillon With Barley Country Sausage Corn Fritter, Sirup Tossed Vegetable Salad With French Dressing Frozen Strawberries Pinwheel Cookies
25 Grapefruit Half French Toast, Maple Sirup • Fried Chicken, Pan Gravy Escalloped Potatoes Baked Acorn Squash Spiced Melon Pickles Chocolate Marshmallow Sundae • Tomato Bouillon Barbecued Beef on Toasted Bun Creamed Spinach Spiced Peach Salad Fresh Fruit Cup Sunshine Cake	**26** Blended Juice Poached Egg, Bacon • Swiss Steak Whipped Potatoes Ford Hook Lima Beans Tomato Salad Mocha Square • Cream of Tomato Soup Grilled Frankfurter Roll Sauerkraut Grapefruit and Orange Sections With French Dressing Prune Whip	**27** Grapefruit Juice Scrambled Eggs, Muffin • Roast Leg of Veal Mashed Sweet Potatoes Creamed Celery Pecan Pie • Cream of Corn Soup Stuffed Peppers (Rice, Meat, Tomatoes) Wax Beans Shredded Lettuce With 1000 Island Dressing Sliced Banana Molasses Cake	**28** Orange Juice Soft Cooked Egg, Roll • Corned Beef, Mustard Boiled Potato New Cabbage Wedge Molded Vegetable Salad Indian Pudding • Mongole Soup Grilled Beef and Pork Pattie Fried Apple Slice Garden Peas Carrot and Olive Salad Stewed Purple Plums Oatmeal Cookie	**29** Pineapple Juice Fried Egg, Corn Muffin • Ragout of Beef Baked Idaho Potato Diced Yellow Turnips Assorted Relishes Mince Pie • Cream of Spinach Soup Corn Beef Hash With Chili Sauce French String Beans Chef's Salad With Chiffonade Dressing Stewed Pear Half Butter Cookie	**30** Grapefruit Half Baron, Salt Roll • Scallops, Tartare Sauce Whipped Potatoes Harvard Beets Coleslaw Dutch Apple Pie • Cream of Pea Soup Toasted Cheese Sandwich Porcupine Salad Compote of Fruit Ginger Cookie
31 Orange Juice, Fried Egg, Raisin Muffin • Baked Virginia Ham Steak, Grilled Pineapple, Baked Whipped Sweet Potatoes With Browned Marshmallows, Chopped Spinach, Halloween Salad, Lemon Chiffon Pie • Black Bean Soup, Pigs in Blanket, Buttered Asparagus, Orange and Stuffed Date Salad, Halloween Cream Puff.					

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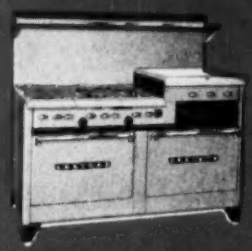
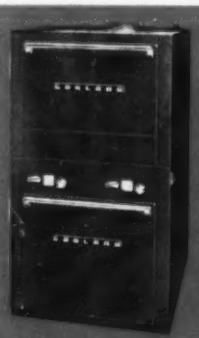
22 SERIES OPEN TOP RANGE. Four open type burners for all purpose cooking (or Hot Top and fry top).

RESTAURANT RANGE. Model 182: One oven, griddle and broiler, open top or combination hot top sections.

RESTAURANT RANGE. Model 194: Two ovens, open top, hot top, griddle sections in any combination desired.



RESTAURANT RANGE. Model 183GG: Two ovens, griddle and broiler, open top or combination hot top.



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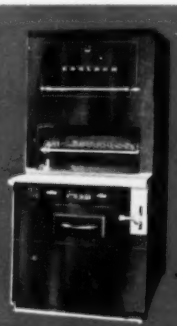

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How to Determine Laundry Costs

ROBERT PENN
Certified Public Accountant
Chicago

THERE are two main cost groups in the laundry department, namely, direct costs and indirect costs. The direct costs include laundry salaries and supplies, and the indirect costs consist of the pro rata share of expenses of departments rendering services to the laundry, *i.e.* administration, dietary, heat, light, power and water, maintenance and repairs, and perhaps personnel quarters. Inasmuch as the laundry department supervisor has control over the direct costs only, it is well for the hospital to establish a sharp distinction between the two groups of costs.

Assuming the hospital accountant maintains the books of account in accordance with the chart of accounts recommended by the American Hospital Association, there should be no difficulty in establishing the direct costs.

But when we enter the realm of indirect costs applicable to the laundry we encounter difficulties. This procedure requires accurate statistical data, proper relationships, and good judgment to compute the departmental apportionments.

Recently we made a cost analysis of a 250 bed hospital and we determined the indirect costs applicable to the laundry. Table 1 is a percentage tabulation of the various costs—both direct and indirect—in this hospital, before provision for depreciation.

Otherwise stated, the total indirect expenses represented approximately 45 per cent of the total direct expenses of the department.

The American Institute of Laundering issued a report for the year 1951 which shows the percentage tabulation of costs of laundries having a weekly sales volume of less than $2000 (see Table 2).

Table 1—Analysis of Costs of 250 Bed Hospital Applicable to the Laundry

Costs	Per Cent	
Direct expenses:		
Salaries	64.5	
Supplies and expense	4.4	
		68.9
Indirect expenses:		
Heat, light, power and water		
Fuel	3.4	
Water	0.9	
Other	2.7	
Administration	9.2	
Dietary	9.6	
Maintenance and repairs	2.1	
Personnel quarters	3.2	
		31.1
		100.0

Table 2—Costs of Laundries With Weekly Sales Volume Under $2000

Costs	Per Cent	
Labor	36.22	
Supplies	10.71	
Direct power costs	7.98	
Building and overhead costs	2.29	
Machinery overhead costs	4.98	
Indirect overhead costs	6.52	
Total laundering costs		68.70
Direct collection and delivery costs	16.91	
Sales promotion costs	1.73	
Direct office costs	4.90	
Direct administrative costs	3.58	
		27.12
Total operating costs		95.82
Operating profit before federal income taxes		4.18
		100.0

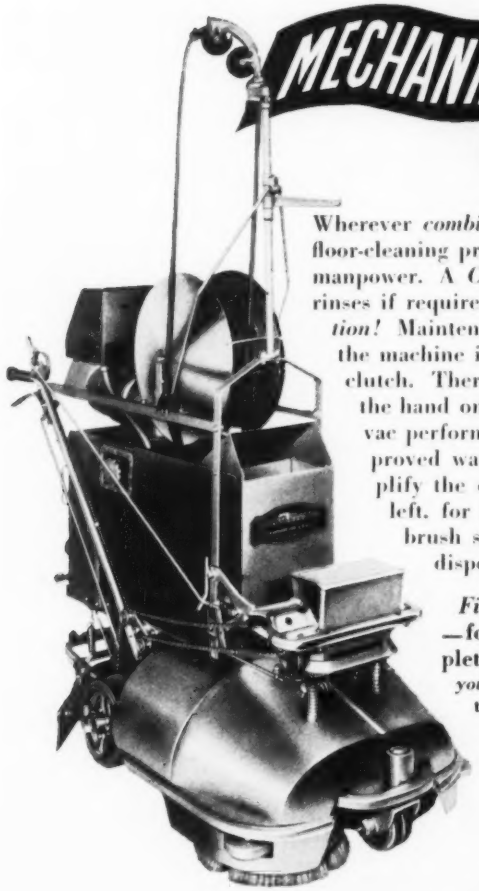
It should be mentioned at this point that the commercial laundry costs included approximately 6 per cent for depreciation, 3 per cent for personal property, real estate and unemployment taxes.

It is also interesting to note that the cost of collection, delivery, sales promotion, and so forth—items that are normal expenditures for a commercial laundry but not applicable to a hospital—aggregate approximately 27 per cent of the total cost of operations. The "laundering costs" mentioned previously are reasonably comparable with the total costs, direct and indirect, of a hospital; hence it is apparent that a commercial laundry disburses approximately 40 per cent additional of such total costs for collection, delivery, and sales promotion. It is obvious, therefore, that this situation gives the hospital a distinct advantage over the commercial laundry purely from the standpoint of operating costs.

The work performed in the laundry consists of flatwork, rough dry and press work, such as uniforms, doctors' pants, coats and shirts, for practically every department in the hospital. Another important phase of determining laundry costs is the apportionment of such cost to the various departments of the hospital. It is the practice in some hospitals to allocate the costs of laundry furnished the various departments on the basis of weight only, that is, the cost of all the work done

Let's not clean away dollars and man-hours with costly, inadequate floor care

MECHANIZE *your floor-cleaning with a* COMBINATION SCRUBBER-VAC!



Wherever *combination-machine-scrubbing* is the practical solution to the floor-cleaning problem, any lesser, slower method is wasteful of money and manpower. A *Combination Scrubber-Vac* applies the cleanser, scrubs, rinses if required, and picks up (damp-dries the floor) — *all in one operation!* Maintenance men like the *four-in-one feature* . . . also the fact that the machine is simple to operate. It's *self-propelled*, and has a *positive* clutch. There are no switches to set for *fast* or *slow* — slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs efficiently and quietly. Cable reel is self-winding. Improved waterproof wiring and minimum electrical connections simplify the cleaning of the machine. *Model 213P Scrubber-Vac* at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread, and cleans up to 8,750 sq. ft. per hour! (Powder dispenser is optional.)

Finnell makes *Scrubber-Vac Machines* in a full range of sizes — for small, vast, and intermediate operations. From this complete line, you can choose the size that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac*, and that *there's a Finnell man nearby* to help train your maintenance operators in the proper use of the machine . . . to recommend cleaning schedules for most effectual care . . . and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1409 East St., Elkhart, Ind. Branch Offices in all principal cities of the United States and Canada.

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50th Anniversary — FINNELL

BRANCHES IN ALL PRINCIPAL CITIES

in the laundry is divided by the total number of pounds; thereby an average cost per pound is arrived at. We do not recommend this procedure because there is a considerable difference in cost between a pound of press work and a pound of flatwork. Obviously, the former is costlier. Furthermore, there might be a wide variation between the quantity of press work from month to month as compared with the flatwork.

It would require a considerable amount of work to determine the actual direct cost of flatwork, rough dry and each item of press work. Therefore, in order to obtain reasonably accurate information for the purpose of allocating the cost to the various departments we recommend that the laundry cost be apportioned on the basis of the related cost of the various items of work performed rather than the average cost per pound of all laundry. This computation is not as difficult as it sounds.

First the commercial value is determined of the work done in the laundry. The commercial unit prices may be readily obtained from the local commercial laundry. Then, it is simply a matter of arithmetic. Let us assume that the total commercial value is $2000 for the month, and the laundry direct costs amount to $1000. Hence, it is reasonable to assume for the purpose of cost allocation that the direct cost to be apportioned to the revenue producing departments is approximately 50 per cent of the commercial laundry charges.

Another advantage of determining the commercial value of the work done in the laundry is that management is furnished with an excellent yardstick of its operations.

Obviously an important factor in the amount of cost is the quality of work performed, and this is difficult to evaluate. This factor does not enter into the cost apportionment as only the actual costs are allocated to the various departments.

Another important item in comparing the work of the hospital with that of the commercial laundry is the cost of replacing linen.

Although good accounting requires that indirect costs be allocated to the laundry to determine the total cost as an operating unit, this procedure should not be followed if management wishes to determine whether the laundry should be continued or abolished. For this purpose, we recommend the "avoidable" cost concept as a basis. This method, in effect, determines the cost on the basis of cash outlay; to the direct costs should be added only those items that necessitate a cash expenditure, such as fuel and water. The total cost thus determined should then be compared with the charges of a commercial laundry. As commented upon previously, some consideration should be given to the quality of work and to the estimated difference in cost of linen replacements.

To summarize, the laundry department of a hospital has a distinct advantage over a commercial laundry in that certain overhead expenses incurred by the commercial laundry are not present in a hospital operation.

The average cost per pound method generally used by hospitals for the purpose of allocating costs of laundry services to the various departments is, we believe, inaccurate. In lieu of detailed accurate costs we recommend the "commercial value" method.

In determining whether the laundry department should be discontinued it is advisable to use the concept of "avoidable cost."

Conducted by Alta M. Le Belle and Jane Barton

The V.A. Sets Up Housekeeping

TRAINING MANUAL ON DUSTING—I

FOUR Housekeeping Training Guides, covering sweeping, dusting, waxing and mopping, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the first section of the manual on dusting. The manual on sweeping appeared in January, February and March, and the mopping guide was presented in five sections — April through August. The second section of the dusting manual will appear in the October issue of this magazine.—ED.

OPERATION DUST PROOF

This is DUSTY... who wages a one gal war on dust in VA hospitals.

Dusty plans to outwit that subversive invader DUST... with its army of bacteria

...its dust-puppy ground force... its winged air force... and its bacterial warfare group. She routes out the enemy wherever they attack. She DUSTS THEM OFF... and she also POLISHES THEM OFF.

The basic points of vital importance which Dusty hopes to inculcate into the minds of the custodial worker are these:

1. Importance of public relations
2. Sanitation features of the job
3. Safety features of the job
4. Use of proper equipment for each job
5. Technics of doing the job
6. Better performance through better training
7. Job pride in his work
8. Valid reasons why the job needs to be done
9. To reduce the "dead-end" point of view of the employe so that he will learn to respect his place on the hospital patient-care team
10. To encourage stability of worker so that the turnover will be reduced.

1. The instructor should emphasize that there is much more to dusting than just swinging a dust cloth about. As a matter of fact a good duster never swings a dust cloth about in the air; the dust would just recirculate and light upon the articles she had just finished dusting.

   Make a few comments upon the incrustations which come upon neglected surfaces, especially if there has been spillage of sticky or unpleasant materials. Point out that even layers of oily furniture polish which have collected a lot of day-to-day soil and have not been periodically washed off will form a "mucky" film.

   Some metal objects will get rusty if the protective coating is broken and the raw metal is exposed to spillage or the dampness of undried surfaces.

   Other metals that are exposed to the elements gather a patina or a discoloration or bluish film. Dusty sees to it that metals do not get crusty.

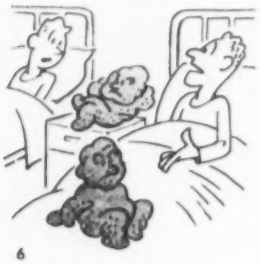
THE INVASION

4

TOO BAD... if the furniture in this hospital is filled with such dust as this!

5

Even the operating rooms are not safe from the dust army.



6

Dust-puppies have an affinity for patient areas.

7

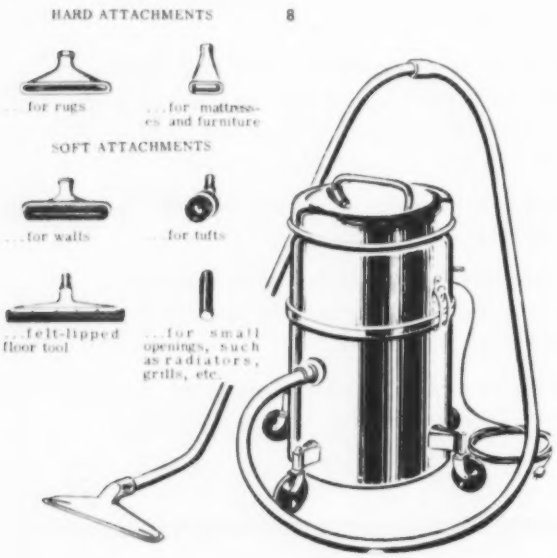
Allergy is this dust-puppies name... he specializes in choking patients.

DUSTY KNOWS ALL ABOUT EQUIPMENT . . .

THE SUCTION MACHINE

The suction machine (more commonly referred to as a vacuum cleaner) is one of the most important dusting tools that Dusty uses. It can be used for every dusting need.

Dusty uses certain attachments on hard surfaces, such as floors... and certain attachments on soft surfaces, such as upholstered furniture.



8

2. There is no greater foe to clean surgery than bacteria laden dust and no greater hazard to patients, whose resistance is already at low ebb, than to receive a cross-infection . . . which can be acquired through dust-borne bacteria or through contact with surfaces which are not aseptically clean.

As Dusty follows the procedure outlined in the "Battle Plan" she carries, she will show how to go a long way toward outwitting the enemy: that subversive invader dust.

3. This word-picture shows that there are dust germs and bacteria everywhere—on the ground, in the air and on every surface. Dusty routs this enemy in every way possible. She dusts, she damp dusts, she uses aseptic cleaning technics, and finally, she *polishes them off.*

4. This diagram illustrates the public relations phase of the dusting requirements. The person making this statement about dust conditions in the hospital represents the parent or friend of the patient, who feels very apprehensive about leaving her loved one in this dirty hospital. This criticism might also come from any member of the professional staff, or from visiting dignitaries, or from members of your community. Anyone who was moved to make such a criticism would certainly not feel friendly toward the hospital.

Dusty is a very important personality in the public relations program of the hospital.

5. A combination of lint and dust could be very serious in a surgical area, whether this area is an operating room, a first-aid room, a ward dressing room, clinic areas, or wherever surgery of any kind is being performed. Bacteria-laden dust puppies are not too proud to invade any area. If it is an operating area, so much the better for them; they can do more damage in such places.

6. There is so much activity in a patient area that many types of dust can get together and develop into fuzzy clumps. There can be combinations of lint, dressings and cotton ravelings, cigaret ashes, bits of debris from O. T. activities, food particles, and many other such items which aggregate into considerable extra work for Dusty. Dusty will have almost a never ending job in the patient areas, both in the bed areas and in the day room and washroom areas.

The instructor should point out that it is vitally important to keep the amount of dust to a minimum in the patient area because the patient's resistance is naturally low and there might be some unhappy results if dust is not kept under control.

7. There are patients who are very susceptible to dust. It is possible that this susceptibility is the reason they are in the hospital. If they as much as breathe dust . . . it may make them very ill. This dust may come from lint, from woolens (blankets), from powders, from cleaning chemicals, and many unsuspected sources.

Dusty always feels a certain responsibility in areas where there are patients who suffer from such allergies, as every hospital housekeeping worker should.

8. There are several tools that can be attached to a suction machine which will simplify Dusty's work. She may choose whichever one is best for the job at hand.

When vacuum cleaning there is one simple formula to follow in selecting the proper tool. This is:

1. On hard surfaces use a "soft" tool.
2. On soft surfaces use a "hard" tool.

Additional recommendations to remember are these:

A brush tool is often useful to unseat some of the more firmly imbedded dust in pores of walls, or recesses, or tufts, or rugs.

A vacuum action cannot reach very far. It cannot get into such recesses as grilles, radiator interiors, and deep upholstering unless a long narrow tool is used which will bring the vacuum close to the dirt.

Please note the *hard* and the *soft* tools which are shown here:

(a) A metal edged tool for rugs. However, if the dirt is deep-seated, it is well also to use a brush tool.

(b) A smaller metal edged attachment to be used on mattresses and furniture. Again, it is often useful to use the brush-edged small tool for some of these chores.

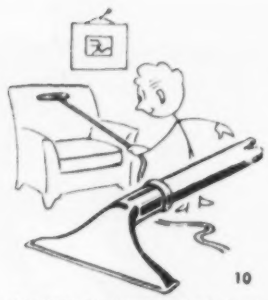
(c) It is usually necessary to use this brush-edged tool for wall dusting, particularly because most wall finishes are quite porous and the dust is often deep-seated and requires a little agitation with the brush tool.

(d) The small brush is nice to use in and under tufts in furniture and mattresses.

(e) The felt-lipped floor attachment is a "soft tool" which is good to use upon floorings.

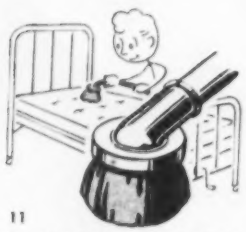
9

By using a long wand... and the correct wall-dusting attachment... high dusting is a cinch.



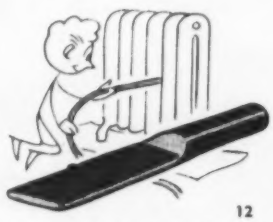
10

This hard attachment pulls dust and dirt not only from the surfaces and the crevices... but it even draws the dirt from clear through the upholstery fabric.



11

This attachment with its small brush helps to dislodge the dirt which hides around tuftings... it goes right after lint.



12

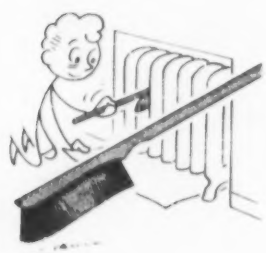
This pointed tool reaches far into small openings and draws out the dust-puppies ... the rubber nozzle tool is also a good one to use in such small openings.

13

The counter brush serves a good dusting purpose for "tops"... sills ... and on steps too.

14

The whisk broom is an able substitute if a vacuum cleaner is not available.



15

The radiator brush is about as long as a rifle... and just about as effective as a rifle, in routing out hidden enemies.

16

This wall duster is a good substitute dust weapon to use when a vacuum cleaner is not available. This weapon is a part of Dusty's Air Defense group.

(f) The small aperture tool fits into small openings where the larger tools will not go.

9. This wand is made of lightweight metal and is very light and easy to operate. It is no more onerous to dust down walls with this lightweight tool than it would be to perform any other vacuum job. This tool is especially good for removing cobwebs and the fluffy particles which rest in the uneven recesses of the wall surface.

It is also useful for performing a thorough wall vacuuming job. This long wand can also be used with what is called a swivel-joint attachment, which is less rigid and will curve. This permits dusting of the overhead pipes and other such surfaces.

10. Here, it is good to stress again the point of using a hard tool on a soft surface. The hard-edged tool holds closer to the fabric surface and thereby permits a stronger suction action.

11. This small circular brush has many uses. It is especially effective for use on the long wand with the swivel-joint attachment. With this attachment it is very simple to dust high ledges and exposed pipes.

12. There are two types of narrow tools for use in small openings. The one shown in the diagram is the conventional type which is a part of every suction sweeper. It has a long nozzle with a thin pointed end which is small enough to get into most apertures.

There is still another small tool which can be made of a short length of garden hose fitted onto the end of an adapter (if necessary) on the wand. This hose tool has the special advantage of being soft and therefore will do no damage to the surfaces being dusted. It is also extremely flexible and can therefore be bent and directed into places that are hard to reach.

13. A vacuum or suction sweeper is not always available, nor does every hospital have them. The fact that they are not available need not deter Dusty from performing her work. She is ingenious enough to use any tools that are provided—and use them to the best of her ability.

On the other hand, the hospital may have an adequate number of suction machines but Dusty dare not use them in certain areas because of the noise or disturbance to the patient. Often the very sick patient cannot tolerate the noise of the motor or the little noises resulting from the use of mechanical equipment. In such instances Dusty has no choice but to use her manual equipment.

Please note that when Dusty sweeps off the tops of counters or other ledges, she does not sweep the litter onto the floor. She is aware that dirt that is swept onto a floor travels through the air, it gets blown around, and lands upon other surfaces. As a result, she will have to perform more dusting jobs.

So, in order to reduce her work, she catches the dust in a dustpan. This is easier in the long run and it is certainly more healthful than "swooshing" up a lot of unnecessary dust.

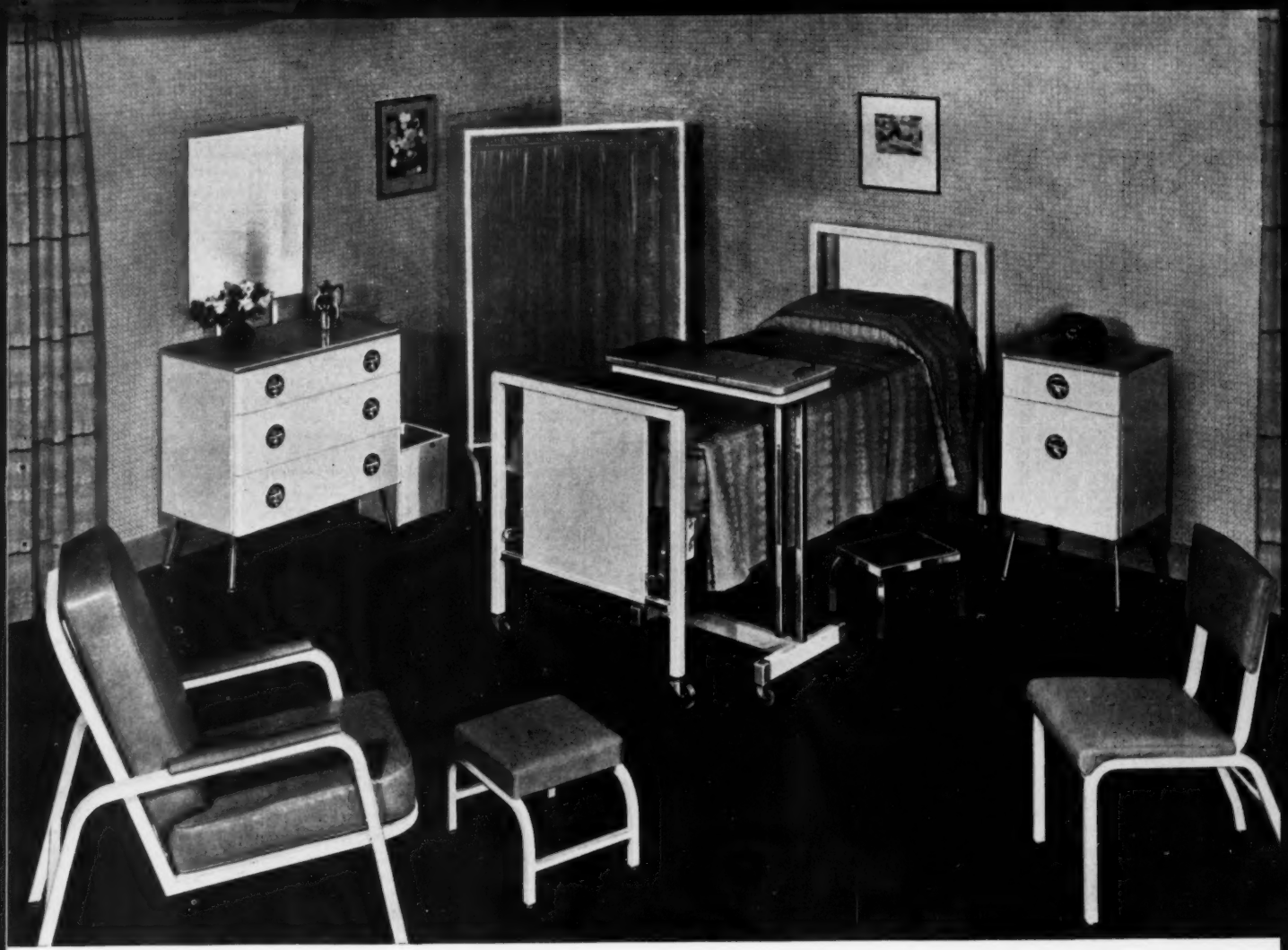
14. There are many uses for a whisk broom in the hospital. It is the least expensive and most effective manual tool with which to sweep the sooty soil off outer window sills. Its broom-straws are just stiff enough to get into corners which are filled with stubborn dirt. It is as nearly ideal a tool as can be used for uncaking packed lint around the tufts of a mattress or a piece of tufted furniture.

15. The merits of the long, slim, soft brush tool hardly require comment; it can fit into most dusty apertures. When it is advisable to reduce the air-borne dust to a minimum, it is often necessary to place a damp cloth over the head of the brush. This damp cloth should be changed as often as it becomes too soiled for further use.

16. Circulating dust, while it rides upon air currents, gathers particles of some substances which are damaging to painted surfaces. When these damaging dust particles are permitted to remain on the painted surfaces for any length of time they also gather some of the humidity from the air. This combination forms a very adhesive and dirty film which is both unsightly and unhealthy.

The longer this film is permitted to remain on the surface, the more damage it will do. Therefore, the more frequently the dust films can be removed through dusting the longer the painted surface will last.

On the other hand, improper use of this dusting method can do even greater damage. It must be used very gently so as not to press the dust particles still further into the



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17

The topside dust-puppy enemies are easy to down with this hand duster. This duster is another of Dusty's Air Defense group.

18

This large duster is one of Dusty's Ground Force weapons...she "grounds" the dust invaders thoroughly with this duster.

19

This small dust mop is one of Dusty's "small operation" tools. ...she uses it in only small crowded areas.

20

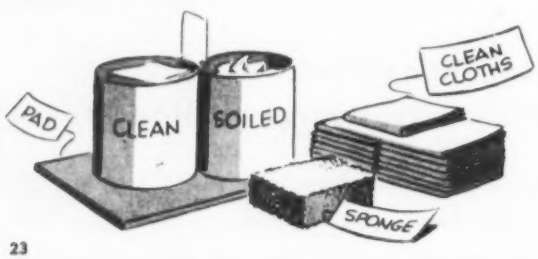
The treated mop is used only on the wood floor. A very few drops of oil on the dust mop will act like a magnet...and absorb the enemy dust particles.

21

Camouflage the broom with a nice clean (sometimes damp) dyed cloth ...never a piece of good linen. This prevents the dust puppies from scattering...and makes them much easier to catch.

22

Dusty keeps the enemy from "gumming her up" by using this special scraper to scrape off wads of gum.



23

This damp-dusting artillary consists of: a pair of pails, one each for the clean damp dust cloths and the soiled dust cloths...a pad to set them on so that they will not water-spot the item upon which they are placed...a sponge for some of the dirtier surfaces...and plenty of clean, lintless cloths.

pores of the painted surface. If the residual dust has absorbed considerable carbon dust and greasy particles this *must not* be massaged into the painted surface during the application of the wall duster.

Therefore, Dusty wishes to emphasize that a very gentle action must be used which will cautiously remove dirt with the least possible effort and the least possible smearing.

17. The first place a "white glove" inspector runs his hand is on high ledges. She works on the premise that if the high areas are dustless so will the lower areas be. This is usually pretty sound logic.

    Many employes are too short to reach the higher areas which need frequent dusting. It is therefore important that an easy high dusting tool be provided. It is much better to provide a long handled duster for them than a step ladder. Too, it is much faster to use than the ladder is.

18. Floor dusting also comes under the general heading of dusting, though as a general rule it is considered a floor cleaning technic. However, when Dusty is called upon to floor-dust she uses the pattern demonstrated by Sweepy in his manual.

19. There are only a few places in the hospital where a tool as small as this can be used. There may, however, be "round the rug" areas where a larger dust mop would be very awkward.

20. An oil treated dust mop is of very dubious value. Certainly, the bit of oil upon the mop will attract and hold the dust particles better than an untreated mop will. The oil mop, too, will give a fleeting bit of sheen to the floor. This same greasy sheen will re-attract new films of dust more quickly.

21. This is an old-fashioned method of damp sweeping a floor that is rarely used now. In principle it is a better method than using an uncovered broom with which to damp-dust in hospital areas where raising dust might be serious. Other methods shown in the Sweepy and Moppy manuals are better.

22. Gum chewers who attach their unwanted gum wads to furniture and walls make a great deal of work for Dusty. She must always be on the lookout for hidden gum wads. These will not dust off; they must be scraped off. They must also be scraped off before the dusting operation begins else the dusting and the polishing operation may need to be repeated.

23. This assembly of damp-dust equipment is a distinct refinement over any of the equipment heretofore used. It has these advantages:

    1. This pair of twin pails can be made of matching cans which can be obtained from food service. They need only to be rustproof and smooth enough so that they will not injure the worker. They can be anchored together very simply and a small handle can be installed. They should then be labeled—one marked *Clean Cloths* and the other container marked *Soiled Cloths.*

    2. Having separate marked containers gives assurance that:

    (a) There will be ample clean cloths to last for an extended dusting period and that clean cloths will be used more frequently.

    (b) There will be a neat container for the damp soiled cloths . . . and they will not be unpleasantly strewn over the duster's cart.

    (c) The duster can be started off on her prescribed job with cloths already properly dampened and neatly folded. This has a good effect on everyone's morale, *i.e.*, worker, staff, patient and visitors. The worker will have a greater respect for her dust cloths and will be much more likely to change them frequently when they are so easily available (and so inviting to use). She will also be more careful of the soiled cloths which are usually thrown into the refuse container once they get very soiled. When they are returned to the housekeeping storeroom for replacement there will be greater assurance that all usable cloths are being returned for laundering.

    3. The addition of a cellulose sponge to the duster's kit is helpful when spillage is so great (or so unpleasant) that damp dusting is inadequate.

    4. The absorbent pad to place under the damp dusting equipment is very helpful as a preservative of surfaces. It prevents not only water spotting but also scratching of surfaces.

    5. The extra supply of clean cloths must be provided where the dusting needs are extensive.

Simmons' **Pictura** *adds the modern touch at Chicago Memorial*

Color, warmth, attractive styling — a far cry from the cold institutional atmosphere of yesterday — find expression in this Chicago Memorial Hospital room, recently refurnished with Simmons' new "Pictura" Furniture.

Here is an entirely new concept in steel furniture, blending attractive color and contemporary styling into smooth unbroken lines that mean easy maintenance. "Pictura" does away with protruding pulls. Self-banded Zalmite tops in harmonizing colors are burn, scratch and mar-resistant.

The 100-room Chicago Memorial, Chicago's oldest private hospital, is refurnishing completely with Simmons. They've found by experience that for durability, ease of maintenance, style and beauty, there is no better value than Simmons furniture and equipment. For modernizing or new construction, call your hospital supply dealer, or write Simmons, for helpful advice.

Above: Chicago Memorial Hospital's newly modernized rooms are equipped with Simmons' "Pictura" furniture, as shown here in Slate Gray with Pale Mist.

Bedside Tables are attractively "picture framed" in the style that gives his furniture its name. Illustrated here in Dove Green with Gray, and with self-banded Zalmite top.

"Pictura" Van-D-Dressers serve as vanity, desk and dresser. Shown here in Mocha with Fawn. Has durable steel top.

Display Rooms:
Chicago 54, Merchandise Mart
New York 16, One Park Avenue
San Francisco 11, 295 Bay Street
Atlanta 1, 353 Jones Ave., N. W.
Dallas 9, 8600 Harry Hines Blvd.

SIMMONS COMPANY

CONTRACT DIVISION

BED B-155

The high-style "picture frame" design of these solid panel bed ends is eye-pleasing and practical, too. Designed to take standard box spring and mattress. For real luxury . . . use Simmons "Pictura" bed with Beautyrest Mattress and Box Spring!

Size (outside) 3/3.....38 x 78 inches
or (outside) 4/6.....53 x 78 inches
Height, Head.....34 inches
Foot.....22½ inches

DRESSER F-155-2-BF

Three-drawer dresser. Top drawer has center partition. Shown here with stain and burn-resistant self-banded Zalmite top.

Top.....19 x 38 inches
Height.....32 inches

Pictura

BY SIMMONS

High Styling in Durable Steel

Here are the pieces that make up the new "Pictura" group — a complete line of durable, easy-to-maintain steel furniture for up-to-date hotels and tourist courts.

VAN-D-DRESSER F-155-26

A space-saving vanity, desk, and dresser combination in modern "Pictura" styling. Shown with steel top, and two-tone finish.

Top.....21 x 49½ inches
Height.....30½ inches

DESK F-155-6

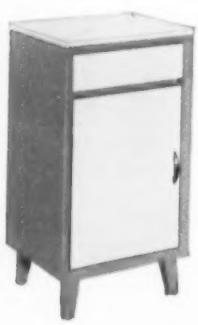
Single desk with large, roomy drawer.

Top.....19 x 33½ inches
Height.....30½ inches

NIGHT TABLE F-155-16

Plenty of room for radio, lamp and clock. Convenient drawer.

Top.....16 x 18½ inches
Height.....28 inches



BEDSIDE CABINET F-455-BF

Shown here with self-banded Zalmite Top.

Top.....19 x 16 inches
Height.....34½ inches

CHEST F-155-24

Large, roomy, perfect for double rooms. Shown with steel top and wood grain finish.

Top.....19 x 30 inches
Height.....41½ inches

Dimensions shown are approximate. For Self-banded Zalmite tops, available on all "Pictura" cases, add ¾ inch to height.

GRIP STAND F-155-15

Has upholstered top of scuff-resistant, easy-to-clean Naugahyde.

Top.....16 x 25 inches
Height.....18 inches

"Pictura" furniture is available in a wide selection of solid color, two-tone and wood grain finishes.

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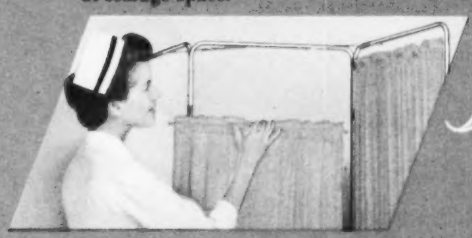
PRESCO *Feather-lite* SCREEN



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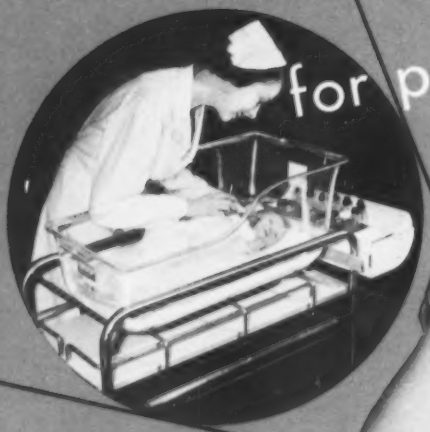

it costs you nothing
to use this
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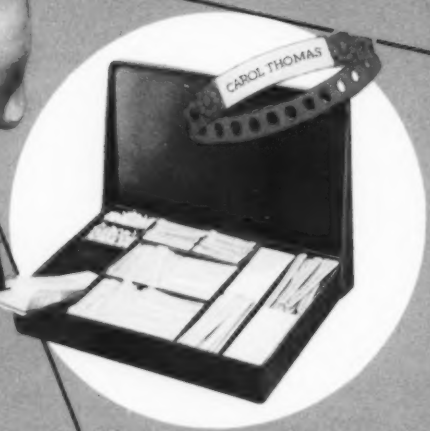
PRESCO SYSTEM



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for ***free samples*** *and the complete story, write the PRESCO COMPANY, INC., Hendersonville, N.C.*

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Internal control methods in 20 hospitals

in regard to their

LINENS, CHINA, GLASSWARE AND SILVERWARE

A. E. MARIEN
Internal Auditing Division, University of Illinois

THIS article examines the reserve and in-service stock controls of the hospital linens, china, glassware and silverware. The principal stock controls looked at in our University of Illinois study were purchasing policies relating to size of stock, central storeroom, requisitioning, inventories (physical and perpetual) and audit checks.

A questionnaire for the study was mailed to a cross section of 50 colleges and universities having a hospital or hospitals.

An over-all return of 67 per cent was realized, including replies made by correspondence. The filled-in questionnaires totaled 20, thus giving a 40 per cent return as far as most of the data were concerned.

The hospitals returning filled-in questionnaires constituted a good representation of all college and university operated hospitals. Twelve of the 20 are general, training or research hospitals, and eight are student hospitals or infirmaries. Nine hospitals, with yearly expenditures of more than $500,000 and up to $3,000,000, are considered large in size; 11 hospitals, with yearly expenditures of less than $500,000, are considered small. The general, training or research hospital is usually large and is operated in connection with a medical school. The student hospital is usually small.

LINENS

Most of the respondent hospitals maintain a reserve stock for linens—91 per cent of respondents. Two hospitals are of the small student infirmary type that do not keep reserve stocks. One of these has access to additional supplies, in each type of stock, in a university central storeroom. The other does not even keep in-service stocks except for linens. Student-patients in this infirmary are fed from an adjoining dormitory kitchen. Closeness of the two student services permit the elimination of a duplication of facilities for feeding.

More than half of the reporting hospitals have a proportion of reserve stock to in-service stock of less than one to one. Almost one-fifth of the hospitals maintain reserve and in-service stocks that are about equal in size. A majority of the respondents (56 per cent) reported they did not increase the size of their normal reserve stock because of the epidemic-preparedness factor. Around a fourth of the hospitals, however, said their reserve linen supplies are one and a half times normal in order to be prepared for epidemics.

In regard to the marking and dating of linens, 19 hospitals replied. Seventy-four per cent place an identification mark on their linens, and 47 per cent date their linens.

Central Storeroom. Eighty-nine per cent of the hospitals responding maintain a central storeroom. Approximately three-fourths of these hospitals place their linen reserve stock in charge of a storekeeper. Five hospitals, or 26 per cent of 19 respondents, give one person access to reserve linen stock; four of these are small student hospitals. Another 26 per cent give

(*Continued on Page* 182)

Every hospital executive should read this story about saving institution interiors.

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INSIDE VIEW OF KALISTRON WALL

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Any wonder Kalistron is called the grandest and toughest wall covering known?

—*and Beauty*

Yet, despite its toughness Kalistron is especially famous for its beauty!

Kalistron is made in 29 colors—to fit into any interior in your building . . . corridors, patient's rooms (great behind beds and other movable furniture), kitchens, pantries, waiting rooms, laboratories. And the colors are not only beautiful themselves but have a double richness because they're seen *through* the Vinylite — a 3-DIMENSION depth. Also — flexible Kalistron can be mounted to any curved wall, or around columns.

Furthermore, Kalistron also is supplied with fabric back to make *perfect* upholstering on furniture that will match the walls.

Best—cleaning ease

Yet, with all these many advantages, hospital men say Kalistron's really top attraction for them is cleaning ease. Dirt just slips off that smooth Vinylite surface. A WIPE WITH A DAMP CLOTH AND — *KALISTRON IS CLEAN!*

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MEDICAL AUDITING

(*Continued From Page 12*)

"Why certainly, Doctor B. Glad to oblige. Just make out the consultation form and put it in my pigeonhole. I'll sign it when I come to the hospital in the morning."

They tell me frankly that that's the way they do it, and that it's the only practical way. In the navy we used to call those "radar consultations," because they could be done at any distance, without the patient actually being seen. It is far from filling the requirement that the consultation be at the bedside, with the conclusion reached after careful examination of patient and circumstances.

• • •

"Which is better, the open staff or the closed staff organization?" That is one of the commonest questions, and is one to which there can be several wrong answers. There is an excellent discussion of it in Dr. MacEachern's bible. The answer is that local conditions, in the community and in the hospital, must form the basis for the decision. There is no general answer.

• • •

The medical audit can pay for itself in improved relations with insurers. In one hospital, located on a main highway, it was noted that many accident victims were removed to other hospitals as soon as it could be done with safety. The accident reports were scanty, lacking in many details that would be important in settlement of the case. Conference of a staff committee with insurers was suggested, to agree on what data should be entered on the report and to find what unsatisfactory conditions in the hospital could be corrected, so that patients would be retained until full recovery. Several months later a letter stated that relations were greatly improved, to the benefit of all hands.

• • •

Consultations can be a reliable guide to a physician's ability and personality. When he calls frequently for consultation for his seriously ill patients, it is likely that he fits Dr. MacEachern's definition of a good doctor—one who understands his own limitations and calls for help when he needs it. When he is frequently called in consultation by his colleagues, it is a tribute to his ability, experience and good judgment. His colleagues show their confidence in his character and benevolence.

• • •

The American Academy of General Practice has done nobly in bridging the gap between specialist and general practitioner. The basic difference between the two groups was recognized both in the profession and by the public. The specialist represented a higher level of training and ability. The Academy has required its members to improve their competence by postgraduate refresher courses and has recently dropped several hundred who failed to keep up with the procession.

The medical audit offers a way to assess the value of those training courses to the individual practitioner. Do his clinical records indicate that he began doing an unreasonably large number of difficult operations that he saw or heard about during the instruction? Does he use the new and powerful remedies with good judgment, or indiscriminately? Does he present an intelligent summary of his new knowledge in medical staff meetings or clinico-pathological conferences? Do his colleagues show their confidence by calling him for consultation in cases that need the new methods and agents he has learned about? The examiner finds many leads that suggest how the doctor spent his time.

• • •

"In every successful outfit there's always an SOB somewhere near the top." That is a navy tradition of long and honorable ancestry. I have concluded that the medical staff needs at least two of those hard guys, one to head the records committee and one for the credentials committee.

• • •

Hundreds of sheets in the clinical records of this hospital contain important data, but have no patient's name or anything to indicate to whom they pertain. This might not be important if all the sheets remain securely in their jackets. In one hospital that I visited a pupil nurse, carrying an armful of records, fell and scrambled them all. The many sheets with no names represented wasted time and labor. Many hospitals have a rule making the ward nurse responsible for having the patient's name on every record sheet.

When I told this R.N. administrator about the fire hazard of the accumulated waste in the hospital basement, she sprang to her feet so violently that her chair fell over backward. "I'll bawl out every man who works there," she cried. That matter of sex antagonism seemed to dominate her administrative policies. She was as bouncy and aggressive as the burlesque actress who muttered, as she wriggled into her scanty costume, "I'll go out there and I'll show those men a thing or two."

I have listened to several dissertations on the shortcomings of nurses as administrators, based largely on sex antagonisms. Strangely enough, they were always spoken by nurses. I have seen many hospitals admirably run by R.N.'s, and very few poor ones. Those run by nurses average very high in the scale. Indoctrination with moral and ethical principles seems to last much longer, without fading or warping, in women than it does in men.

• • •

The objects of the medical audit are often misunderstood. They are:

1. To assay the competence of each individual doctor, and his value as a member of the hospital team.
2. To provide a guide for granting hospital privileges.
3. To bring to the attention of the management and the medical staff any conditions that might well be improved.

It may also provide answers to many questions such as these:

Are insured patients being retained for too long a time?

Is it true that private patients get poorer care than others?

Is the hospital's organization for disaster adequate?

Are the trustees educated in their duties and responsibilities?

Are the pathological and radiological services adequate?

Are the constitution and by-laws suitable, and enforced?

What kind of job is the administrator doing?

Does the hospital fill the needs of the community?

How is the tissue committee functioning? The surgical and other departmental committees?

Is a joint-conference committee needed?

Does the desire for the welfare of the patient dominate the hospital?

How can public relations be improved?—LUCIUS W. JOHNSON, M.D.

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Depreciation Accounting

(*Continued From Page 75*)

hospital may well seek sufficient revenue so that from it there can be provided the eventual replacement of its equipment and even its buildings, partially or fully. Provision for depreciation to cover such needs would be appropriate. However, that can only be accomplished when cash from income is actually set aside for such replacements.

Consequently, a procedure of accounting which would recognize depreciation and the necessity for replacement but at the same time actually make provision for it by regular reduction in general surplus and also set aside funds for replacement could be carried out as follows (again using the figures in the November 1951 American Institute problem):

General Fund:
Dr. Provision for Depreciation $29,848
Cr. Reserve for Replacements $29,848

Preferably this cash would be at once transferred to Plant Fund. When replacements are made:

Plant Fund:
Dr. Reserve for Replacement $11,432
Cr. Cash $11,432

As indicated by the College and University Committee, the mere setting up of a "reserve for depreciation" in plant funds, with a corresponding reduction in "plant investment" account, serves no worth-while purpose.

Some hospital buildings are financed by loans repayable, principal and interest, out of income. When this is the case, net operating income is expected to be sufficient to cover annual debt service. As to principal payments under such a program, such provision is similar, though not identical in either amount or principal, to provision for depreciation. When such provision for debt service has to be made, however, it would be inequitable, as well as usually impossible, to provide also for depreciation, or for other than ordinary replacements, out of current income.

This paper is not intended to be an argument against provision out of current income of hospitals for sums needed for replacement of facilities. It is in opposition to a bookkeeping charge of depreciation, unless a corresponding amount of cash is set aside from current funds to be available for future replacement expenditures.

It particularly decries the plan of depreciation accounting where the item is entered as an expense and then offset by a fictitious credit through reduction of the account for investment in plant, leaving current surplus unaffected by the depreciation entry. No precedent in any kind of accounting will be found for such a procedure, and I believe that no beneficial result can possibly accrue from it.

This brief review should also indicate that there are serious discrepancies in theory in the discussion of this subject, as well as wide variations in practice. Judging by financial reports available, there is a great diversity not only of procedure but also in the character and adequacy of reports. The conclusion is that there is great need for further intensive study of many problems and procedures in hospital accounting and reporting, and for improvement in both standards and application.

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NEWS DIGEST

San Francisco A.H.A. Host for Third Time . . . Nonclinical Specialists Weigh Problems . . . "Federal Medical Supermarkets" Attacked . . . Report on Survey on Internal Stock Control of Linens, Silver . . . Movie Program for Outpatients

San Francisco Host to A.H.A. Convention for Third Time

CHICAGO.—As this issue of The MODERN HOSPITAL went to press in late August, hospital administrators, trustees, auxiliary members and executive department heads from all over the country were on their way to San Francisco for the 55th annual convention of the American Hospital Association beginning August 31.

It was the first time since 1928 that an A.H.A. meeting was held on the West Coast, and the third time in association history. Unquestionably, travel time and expense would cut attendance below peaks reached at eastern and midwestern conventions, but the indications were that the attendance loss would not be greater than one-fourth. Many administrators were motoring west with their families, planning to make the convention a part of their vacation trips.

Headquarters for convention exhibits and meetings was the San Francisco Civic Auditorium, where exhibits spilled over from the main hall into an adjoining pavilion. Headquarters hotel for the convention was the Palace, where the association's House of Delegates was scheduled to meet on Sunday morning, August 30, and again Wednesday evening.

Important problems to be considered by the delegates were the new statement on physician-hospital relations developed by a joint committee of the American Hospital Association and American Medical Association boards of trustees and approved by the A.M.A. house of delegates last June, and a proposal to increase hospital representation in the accreditation program for schools of nursing, but not to establish an accreditation program within the American Hospital Association itself, as some delegates had recommended last year.

During the convention, honorary memberships were to be awarded to Basil O'Connor, president of the National Foundation for Infantile Paralysis, and to Dr. James M. Mackintosh, professor of public health at the University of London School of Hygiene and Tropical Medicine, who made the trip to the United States especially to attend the hospital convention.

The association's Award of Merit for 1953 was to be given to Dr. Basil C. MacLean of Rochester, N.Y., at the annual banquet Thursday evening.

As was the case the first time last year at Philadelphia, the San Francisco convention program featured panel discussions and informal presentations, as opposed to formal addresses. Topics for the discussions, as usual, included hospital financing, organizing community support, personnel, staff problems, nursing, food service, management technics and human relations,

(*Continued on Page* 156)

Nonclinical Specialists' Problems Are Weighed at A.A.M.C. Meeting

CHARLOTTESVILLE, VA.— A roundtable discussion on the rôle of the pathologist, radiologist and anesthesiologist featured the last annual session of the American Association of Medical Clinics and was reported in detail in the association's *Bulletin*, published here last month.

Opening the discussion, Dr. Frank L. McPhail, moderator, declared that in many sections of the country these "nonclinical specialists" are denied their rightful place in the practice of medicine. "This may be described as a result of evolution and need not be directly the responsibility of these specialists or of the medical profession as a whole," Dr. McPhail said.

Elaborating on the problem, Dr. McPhail continued: "The nonclinical specialist must gain a great deal of technical satisfaction from his work.

(*Continued on Page* 158)

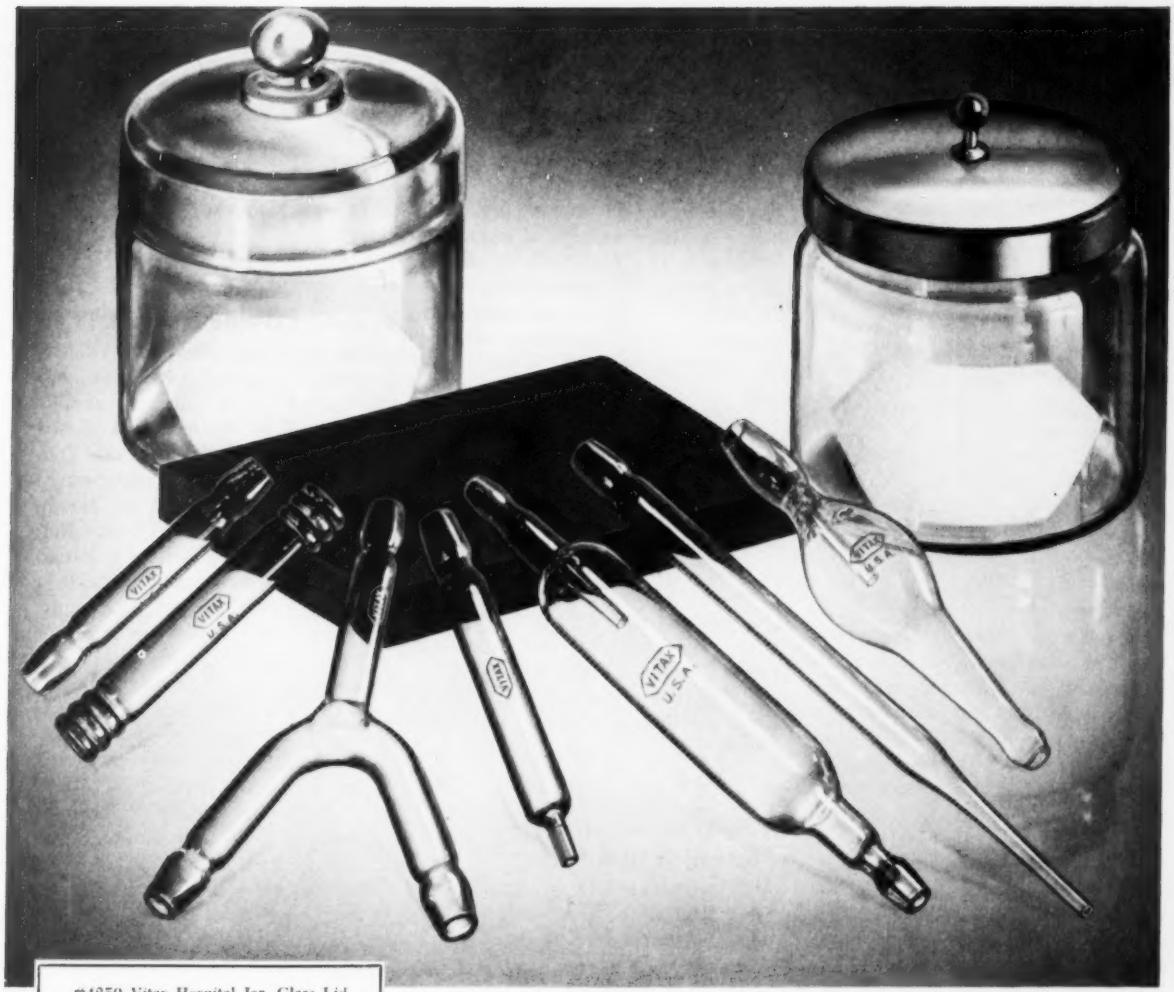
Pace Associates Are Hospital of Month Architects

CHICAGO. — Through a misunderstanding, credit for the Fayette County Memorial Hospital of Vandalia, Ill., which received the "Modern Hospital of the Month" award for August 1953, was given to Morris C. Hertel of Chicago, presently a member of the architectural firm of Hertel, Johnson, Eipper, Stopa and Culver. Architects for the project, which is now under construction at Vandalia, are Pace Associates, Chicago, planners, architects and consulting engineers. W. H. Binford, a member of the Pace firm, is the supervising architect.

Mr. Hertel, who wrote the article which appeared on page 55 of The MODERN HOSPITAL for August 1953, was formerly a member of the Pace organization and was active in the development of the hospital plan, carrying on as architect with Mr. Binford until the original Pace partnership was dissolved several months ago. Since that time, Mr. Hertel has been employed by Pace Associates as an architectural consultant on the project.

Model of Fayette County Hospital

The Modern Hospital of the Month certificate has been issued to Pace Associates.



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NEWS...

A.M.A. President Warns Against Federal Medical Supermarkets

DENVER.—Dr. Edward J. McCormick, president of the American Medical Association, speaking before the Rocky Mountain Radiological Society's midsummer conference here last month, called for a halt in the expansion of federal medical care for veterans with nonservice disabilities.

These "federally operated medical supermarkets," he said, are detrimental to the health and economy of the entire nation.

"Continued progress in medicine, as in any other field of free enterprise, is best achieved without interference from a highly centralized government authority," Dr. McCormick told the group.

"Preferential treatment for veterans with nonservice disabilities cannot be continued indefinitely in view of the detrimental effect on the health and economy of the entire nation," the Toledo surgeon declared.

Dr. McCormick stressed that the American Medical Association does not seek to eliminate the well deserved, free medical care for veterans with service disabilities. "On the contrary," he said, "it seeks to improve the quality, availability and efficiency of such care by taking out of V.A. hospitals large numbers of patients whose disabilities would have developed even if they had not seen a single hour of military service."

He said that veterans' medical care and hospitalization benefits should be limited to: (1) veterans with peacetime or war-time service whose disabilities or diseases are service incurred or aggravated and (2) within the limits of existing facilities, to veterans with war-time service suffering from tuberculosis, psychiatric or neurological disorders of nonservice origin who are unable to defray the expenses of necessary hospitalization.

The provision of medical care and hospitalization in V.A. hospitals for the remaining groups of veterans with nonservice disabilities should be discontinued and the responsibility for the care of such veterans should revert to the individual and to the community, he added.

Explaining that he did not believe everyone seeking to bring about federal subsidization of medical care is purposely working against the best interest of the people, Dr. McCormick said: "There are many zealots among them who sincerely believe in what they are doing. Their greatest fault is that they are woefully ignorant of basic medical economics. And some, such as leaders of certain veterans' organizations, . . . claim preferential status for all veterans. In a democratic nation we cannot have two types of citizenship. To serve one's country is a duty and an honor, and the only claim that any of us have as basic right is that principle for which we fought—individual freedom and dignity. We did not follow the colors to become wards of the government."

Dr. McCormick pointed out that there are about 20,000,000 veterans in this country and that the number is increasing at a rate of 1,000,000 annually. He cited government figures showing that of the 511,895 patients who were discharged from V.A. hospitals during the fiscal year of 1951, 432,995 (84.6 per cent) were treated for nonservice disabilities, and only 78,900 for service ailments.

Two U.M.W. Hospitals Started in Kentucky

WASHINGTON, D.C. — Labor Day ground-breaking ceremonies were scheduled for two hospitals in the 10 hospital chain being constructed by the United Mine Workers Welfare and Retirement Fund, it was announced here last month. The new hospitals are to be built at Harlan and Pikeville, Ky., Dr. Warren F. Draper, executive medical officer of the welfare fund, said.

The Harlan hospital, designed by Sherlock, Smith and Adams of Montgomery, Ala., will have 192 beds and 30 bassinets and is one of three "base hospitals" in the program. The Pikeville hospital was designed by York and Sawyer, New York, for 50 beds and is listed as a community hospital, to be affiliated with one of the base hospitals in the chain.

"By mid-autumn, construction of the entire loop of modern structures will be under way to provide medical care for Fund beneficiaries," the announcement said. "In addition to meeting primary needs of miners and their families, the hospitals will serve the communities in general insofar as accommodations permit."

In addition to Dr. Draper, those taking part in the ground-breaking ceremonies will be Dr. Fred D. Mott, administrator of the hospital construction program; Dr. John T. Morrison, assistant medical officer, and Dr. John D. Winebrenner, area medical administrator with headquarters at Knoxville, Tenn.

Fern Gleiser Named A.D.A. President-Elect

LOS ANGELES.—Fern W. Gleiser, professor of institution economics and management at the University of Chicago School of Business, was named president-elect of the American Dietetic Association at the association's 36th annual meeting here last month. Miss Gleiser will succeed Grace Bulman, chief of the dietetic division of the Veterans Administration, who took office as president during the meeting, succeeding Beulah Hunzicker, director of the dietary department at Presbyterian Hospital, Chicago.

In addition to Miss Gleiser and Miss Bulman, other members of the association's executive board are Dr. E. Neige Todhunter, dean of the school of home economics at the University of Alabama, and Doris T. Odle, director of dietetics at the University of Colorado Medical Center, Denver. Esther A. Atkinson, professor of hotel and institution administration at Pennsylvania State College, is secretary.

Dr. Frank Bradley, director of Barnes Hospital, St. Louis, made the presentation of the Marjorie Hulsizer Copher award to Mable M. MacLachlan who was director of the dietary department of the University of Michigan Hospital, Ann Arbor, and who has recently retired after serving for five years as educational director of the association.

A report of the proceedings of the convention will appear in The MODERN HOSPITAL next month.

St. Vincent's Adds Wing

NEW YORK.—Plans for the erection of a $2,500,000 psychiatric treatment addition to St. Vincent's Hospital were announced here last month by the hospital. Sr. Loretto Bernard, administrator, said that Eggers and Higgins, the architects, expect to complete the seven-story, fireproof building about September 1955. The new facility will add 80 beds to the hospital's complement of 715.

Movies While They Wait

Outpatients learn health facts under three-year experimental film program

HERBERT R. EDWARDS, M.D.
Executive Director
N.Y. Tuberculosis and Health Association

ABRAHAM ROSENBERG
Executive Director
Hospital for Joint Diseases

New York City

AN OUTPATIENT department of a hospital can prove to be an effective way to reach people with health education. The recently published report of an audio-visual program carried on for the last three years by the Hospital for Joint Diseases and the New York Tuberculosis Association shows how waiting hours can be used constructively, and how waiting rooms can become classrooms.

Although the program is carried on in the outpatient department of a hospital in a large city, the principles and procedures can be as effectively applied to hospitals of smaller communities, in addition to other health or welfare centers where people must spend time waiting.

The program described in the report shows how a hospital and a local voluntary health agency can work closely together for the greater benefit of all, how a health agency can reach community groups otherwise unattainable, and how a hospital can become a vital source of community participation and action.

In the Hospital for Joint Diseases the key group has been the volunteer social service committee, which has worked effectively with the professional social service staff and other hospital personnel. The key group in the New York Tuberculosis and Health Association has been its health education team, which includes audio-visual experts and a health educator, who are located in an association branch office near the hospital.

The Hospital for Joint Diseases is a general hospital whose predominant

Many outpatients have a limited knowledge of English. Here the casework supervisor uses "sign language" to answer questions following weekly movie.

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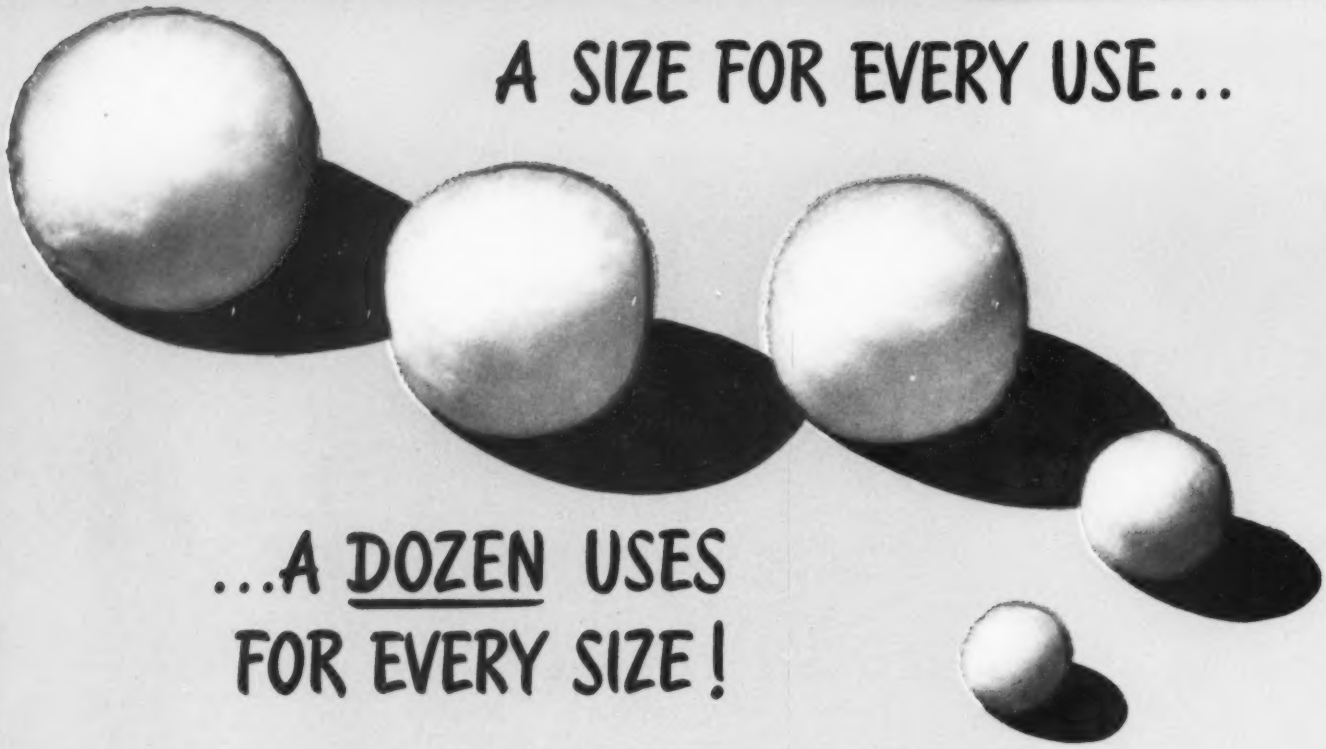

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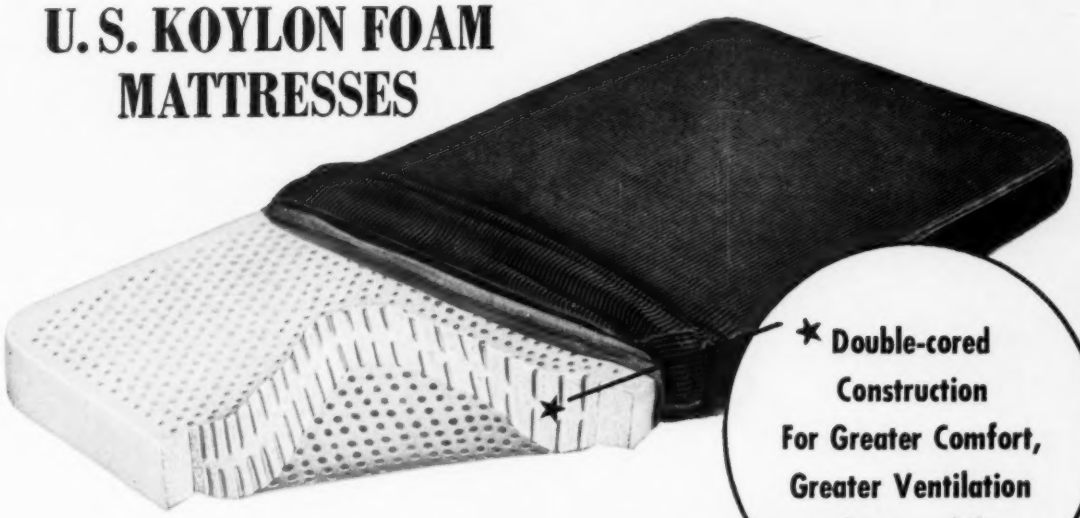

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medical services are in orthopedic surgery and is located at Madison Avenue and 123d Street, New York City. Its outpatient department serves patients from all over the city, but the greatest number live in the immediate vicinity. As is the case with almost every other hospital in the city, the patients are every age, color, and creed; they speak a variety of languages and have a variety of ailments.

The social service committee and the department of social service developed the health education program when they saw the opportunity to use constructively the time which patients spend waiting to see their doctors. Assistance in health education and audio-visual services was available through the tuberculosis association and its Harlem office. At each clinic session is shown a film that has been selected following preview. Preceding presentation of the film, the health educator or the casework supervisor makes some introductory remarks, occasionally a physician or other hospital staff member or an outside resource person shares in leading the discussion.

As the first step in developing the plan for weekly audio-visual programs, the social service committee appointed two of its members to work with the department of social service and an association health educator. A study was made to make certain that films were available in sufficient variety for sustained programs appropriate to the hospital's objectives and the patients' needs. Lists were made of films with Spanish as well as with English sound tracks. Pamphlets and leaflets related to the films were reviewed.

The only place to present the program was the large lobby of the outpatient department. By the time the program was ready to get under way, volunteer members of the committee had bought material for blackout curtains, which were made by the housekeeping department. The occupational therapy department made posters announcing the films, and the Harlem committee provided a literature rack. After the program had been in operation for about a year, it was possible to move projector and audience into a small auditorium.

PRECEDE CLINIC OPENING

Films are shown immediately preceding the hour the clinic opens and are timed to end before the first patient appointment. Before the film, a brief explanation is given by either the Harlem committee health educator or the casework supervisor. At least one member of the volunteer committee is present at each program. She assures the patients that no appointment numbers will be called until the program has ended and that they will not miss their "turn" to see their physician. She also encourages patients to attend the film showings.

It was hoped at the beginning that patients would raise questions in the group. It was found, however, that instead of speaking up in the group they went to the casework supervisor with individual questions. Now some patients, particularly those who attend the movies with regularity, are willing to participate in discussion, and group participation has increased during the year. Some patients come to see the films whether they have clinic appointments or not. The educational literature is actually "gobbled up"—patients

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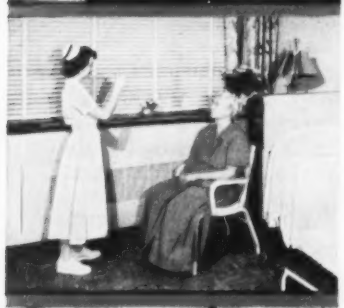

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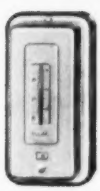

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NEWS...

take it for themselves and for members of their families.

The casework supervisor keeps minutes of each movie shown, including the size and reaction of audience, the content of the movie, and its pertinence and implication to the group. The New York Tuberculosis and Health Association provides the motion picture operator, equipment and most of the films, but occasionally the committe borrows or rents a film from other agencies. A small fund has been established by the social service committee to pay the rental cost of films which cannot be obtained free of charge. The committee members attend previews of films at Columbia University Communications Center and the New York Tuberculosis and Health Association among other places.

Movies have been presented about tuberculosis, nutrition, home safety, child health, rheumatic fever, mental health, rehabilitation, department of health resources, personal hygiene, care of ears, nose and throat, bacterial control, care of the common cold, diabetes, cancer, dental health, human reproduction, and camping services.

When the programs were first being planned, the hospital's committee on health education thought that since many Spanish speaking people attend the outpatient department it would be necessary to confine programs to subjects for which Spanish films could be obtained and preferably to subjects on which a film had been produced in both English and Spanish editions. It has been found, however, that the action of the film helps to make the story clear even to those with little knowledge of English, and that patients who understand English explain obscure points to the others.

IDEAL FILMS NONEXISTENT

Few films have been found to be ideal. However, with the introduction of the film and the opportunity following the showing for group and individual questions, each film has been adapted to the needs of the group. In the main the films available and used have been those produced for general public or school audiences. The subjects most pertinent to patients of the Hospital for Joint Diseases, orthopedic illnesses and rehabilitation, are lacking. There are virtually no films specifically for older people with chronic illnesses or on other health

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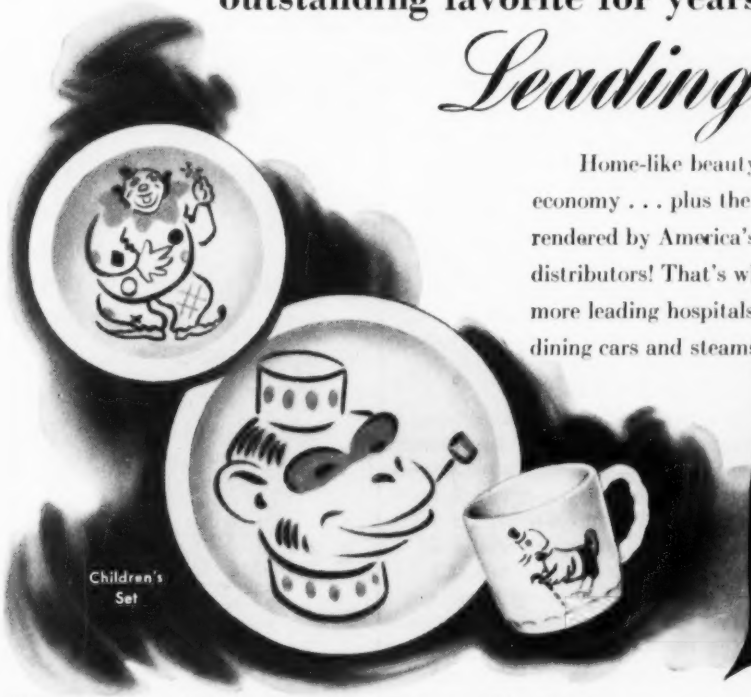

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NEWS...

matters of importance to this age group.

The questions asked after the showing reveal the particular concern of some patients; some of these patients are referred back to the social workers and physicians in the hospital and others to the department of health for x-rays and blood tests. Follow-up of referrals shows that patients generally take advantage of recommendations made to them.

This program has been possible because of the cooperation of many people. Each had a definite responsibility and contributed to the program from a particular professional, community, administrative or other experience. Members of the hospital staff have also benefited, and many drop in for the programs. Social workers are encouraged by their supervisors to attend. Committee and staff members from other hospitals come to observe. The New York Tuberculosis and Health Association staff members have made use of the experience in advice given to other hospitals, and regard this experience as a necessary part of their patient education program.

There are many ways in which the program can be improved. The response of patients after films on venereal diseases are shown warrants the active participation by more physicians in the program. From the beginning, all those involved in the program have seen a medium from which to build group work programs within the hospital setting.

How much the programs have helped patients understand the recommendations of their doctors is difficult to evaluate. But from the nature of the questions asked it is believed that the films have been a definite aid to helping patients understand their part in treatment. Some of the discussions have indicated that the movies have helped patients with family health and medical care problems.

Many patients in the audience are in the older age group. For some time it had been observed that a considerable number of grandmothers, for social and economic reasons, are responsible for bringing up their grandchildren. These women asked for more films on living in the home, on feeding and caring for infants, on feeding the whole family, and on diets for adults who wish to lose weight.

(*Continued on Page* 154)

SAFETY WAS ONLY FOR THE STRONG!

Fool-proof and simple, many "fire protection" devices of a half-century ago were useless for most people. The fire rope, for instance, almost standard in inns and multiple dwellings of our grandfathers' time, spelled safety only for the strong who could lower themselves hand over hand.

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NEWS...

Maternity Bed Shortage in Chicago Now Acute

CHICAGO.—A shortage of obstetric hospital facilities here reached emergency proportions last month when, following an order from the state health department to stop admissions to the maternity section of Cook County Hospital on account of overcrowding, other hospitals throughout the city reported their own maternity facilities occupied at capacity.

At a special meeting of public health and hospital officials called to review the situation, Dr. Herman N. Bundesen, president of the Chicago Board of Health, insisted it was the hospital's responsibility to provide for indigent obstetric patients. "You've got to find space," he told the county hospital authorities.

"We never turn any away," replied Fred Hertwig, Cook County's warden. "That's why we're in trouble now."

Following the order from the Illinois State Health Department, hospitals throughout the city accepted one or two patients each to relieve the overflow crisis. Most of the hospitals, however, reported their own facilities were already jammed to capacity.

"We're right back where we started before the closing," said Mr. Hertwig at the meeting.

Dr. Bundesen reported he would recommend to the Chicago City Council that the 1954 budget include provision for construction of a special city maternity hospital. He estimated the cost of the facility at $3,000,000 to $5,000,000.

Long Island's New Hospital Admits First Patient

MANHASSET, N.Y.—The North Shore Hospital here admitted its first patient on July 27, Administrator Edward James has announced.

A rheumatic fever patient, Vincent Gallo of West Hempsted, L.I., entered the hospital early on the 27th, and was still its only patient that evening. He was brought to the hospital from Long Island Hospital, Brooklyn.

Mr. James said the maternity section and nursery were not ready at the time but that the 40 bassinets would soon be occupied.

The hospital is situated on a 12 acre plot adjoining a large estate. It was built at a cost of $4,000,000 and will serve Great Neck, Manhasset, Port Washington, Sands Point, Douglaston, Little Neck, Plandome and Roslyn.

Philadelphia Again at Top in Blue Cross

CHICAGO.—The Associated Hospital Service of Philadelphia won first place for the fifth time in the "general program" section of the annual Blue Cross-Blue Shield sponsored public relations contest.

Award winners were announced July 24 at the Blue Cross-Blue Shield Public Relations and Enrollment Conference held here. Approximately 225 delegates from Plans of the United States and Canada attended the meeting, officials of Blue Cross said.

The awards were of two kinds: general program awards, based on a

Judges West, Johnston and Jones.

Plan's over-all public relations program for the past year, and project awards, based on programs in six specific categories—subscriber relations, community relations, institutional promotion, enrollment promotion, hospital and physician cooperation, and new market development.

Philadelphia received the award for Plans with an enrollment of more than 500,000.

Winner of the general program award for Plans of less than 200,000 was Associated Hospital Service of Arizona and Arizona Blue Shield Medical Service.

Chicago, Detroit, Portland, Ore., Dallas, Tex., and Durham, N.C., were among winners of project awards.

Judges of the contest were: Paul Jones, director of public information, National Safety Council; Phelps Johnston, vice president and creative director, Campbell Mithun Advertising Agency, and Victor West, public relations department, Standard Oil Company (Indiana).

NEWS...

Movies While They Wait

(*Continued From Page* 150)

Their expressed wish for films on cancer and the like will be explored to determine the reasons behind the requests.

In our joint note of introduction to the published report we say that people coming to an outpatient department for medical treatment have many questions on health and family living that are important to their future health and effectiveness. They need encouragement to bring these questions to doctors, nurses and social workers and they need information to supplement that which these workers give.

Experience has shown during this three-year demonstration that such group programs are successful if they are carefully planned, well organized, and have the active interest and participation of volunteers and professional workers. Any similar center, such as a hospital, clinic or welfare center, where groups are gathered for a period of waiting time, can utilize these hours effectively if the centers are equally interested in doing a job on community resources, health education, and helping people to help themselves.

The essentials for a program, whether in a large or small community, include:

1. The sustained interest and substantial time of volunteer workers.

2. Social service or other personnel within the hospital who are concerned with helping people understand the resources for their treatment and their own part in the treatment and who recognize that healthful living aids in recovery and prevention and that the opportunity of the hospital extends beyond the treatment of the immediate disease. In different settings the key people within the hospital may be nurses, doctors or social workers.

3. Access to a 16 mm. film lending service, preferably within the local community or county, or else in a state department of health, state university, state department of education, the state headquarters of a voluntary health association or a combination of these. Resources in the local community might include a health department, a tuberculosis and health association, other local health agencies, a health council or a public library with a film lending service. It is helpful to have a small fund for film rental fees and for postage.

4. As a resource person, a health educator in a community health agency, health department or voluntary health agency to help develop the program and to stand by. If such a person is not available, perhaps a teacher of health education is, or someone in the community who has had experience in adult education and in methods of helping people to define their interests and to learn in informal settings.

5. A 16 mm. motion picture machine and someone to operate it.

Booklet for Agency Board Members Out

PASADENA, CALIF.—"So—You Serve on a Board," a booklet directed to members of agency boards of directors, was published in July. A result of board member institutes held in 1945, 1949 and 1952 and sponsored by the Volunteer Placement Bureau of Pasadena, the 24 page booklet is now in its third edition.

Take this chair, for instance. There are no dowels or screws to give you trouble. The cushions are loose . . . which makes cleaning a cinch (they're foam rubber, incidentally). Stainless steel glides encased in rubber . . . a Woodard exclusive . . . keep your floors from getting scratched. Yes, for easy and economical maintenance . . . there's nothing like Woodard wrought iron. For style, either . . . for that matter.

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NEWS...

San Francisco Host to A.H.A. Convention

(*Continued From Page* 140)

but the discussion panels included a larger than usual representation of groups outside the hospital field, including many trade association and industrial executives from the West Coast area. The featured speaker at the opening session of the convention was to be Oveta Culp Hobby.

In place of the usual Monday evening reception, dinner or entertainment sponsored by the association, the program offered "A Night on the Town"—a bus tour of San Francisco's night spots at $8 a head.

Featuring the usual preconvention session on hospital design was a talk by Dr. Sydney R. Garfield, medical director of the Permanente Foundation, whose chain of West Coast hospitals has been expanded greatly in recent years. Another speaker on the design program was Dr. John Newdorp, deputy medical administrator of the Memorial Hospital Association of Kentucky, whose 10 unit hospital system is under construction for the United Mine Workers Welfare and Retirement Fund.

Other affiliated groups meeting in San Francisco were the annual Hospital Auxiliaries' Conference, the American Association of Nurse Anesthetists, and the American College of Hospital Administrators, whose convocation was to take place at the San Francisco Opera House on Sunday afternoon.

For the first time, candidates for college fellowship and membership were to wear gowns during the convocation. Seven prominent hospital leaders were scheduled to be honored with honorary college fellowships. They were: Raymond P. Sloan, president of The Modern Hospital Publishing Company; Maj. Gen. George E. Armstrong, surgeon general, Department of the Army; Dr. Leonard A. Scheele, surgeon general, U.S. Public Health Service; Vice Adm. Joel T. Boone, U.S. Navy, retired chief medical director, Veterans Administration; Maj. Gen. Harry G. Armstrong, surgeon general, Department of the Air Force; Karl Philip Meister, executive secretary of the Board of Hospitals and Homes of the Methodist Church, and R. Adm. Lamont Pugh, surgeon general, Department of the Navy.

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Warsaw, New York
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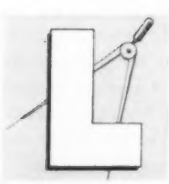

LUDMAN LEADS THE WORLD IN WINDOW ENGINEERING

NEWS...

Nonclinical Specialists' Problems Are Weighed

(*Continued From Page* 140)

If he does not, the fault may lie either with himself or with his colleagues. A radiologist who allows himself to degenerate into a mere film reader, who does not individualize his examinations is dangerously close to losing that most important attribute, the sine qua non, of the physician. In a busy, highly specialized practice, particularly in groups where responsibilities are divided, this is a trap into which it is easy to fall. Because of the peculiarities of his personal services, the nonclinical specialist may easily lose an important part of the patient-physician relationship which is cherished by nearly all physicians. He should be aware constantly of this possibility and must be active in guarding against it. His colleagues, on the other hand, may either deliberately or by an unconscious omission contribute to the dangers outlined. Clinicians vary widely in their handling of these problems; some have a clear understanding and others create serious problems.

"There is at least one more problem. The clinician may serve to block a relationship when he fails to mention the nonclinical specialist to the patient at the time final reports and advice are given. He may even imply that the interpretation is that of the clinician himself. Mention of the nonclinical specialist increases the prestige of the entire organization and elevates the clinician in the eyes of the patient and his family since they must realize that he is enlisting the aid of a group of specialists in their behalf. In addition, the nonclinical specialist would realize the satisfaction of feeling that he is an active participant in the care of the patient."

CHIEF REASON ECONOMIC?

Joining the discussion, an internist contended that the principal reason the nonclinical specialists object to the treatment they have received from other physicians, hospitals and clinics is economic. "Because of their type of training and type of work, these physicians in many places have been largely on a salary basis, being employed full time by either hospitals or clinics, and thus are not considered to be in private practice," the internist stated.

"The radiologist might frequently see a patient with a fractured hip and collect a fee of $10 or $15 for diagnosing the fracture; the anesthetist might collect $30 for the giving of an anesthetic, while the surgeon is collecting a fee of $200 or $300 for his part in the procedure. Lastly, the pathologist, if there is some question of malignancy, for example, might get $5, or possibly $10, for looking at a slide of the specimen. And postoperatively the physician trained in physical medicine would probably get $200 or $300 a call for rehabilitation supervision. This inequality for the same type of specialized work in my opinion is one of the reasons why the various nonclinical specialty groups are agitating for recognition as equals, as far as private practice is concerned, with all the rights thereto, such as billing the patient directly."

After outlining in some detail the responsibilities of the anesthesiologist, radiologist and pathologist, the internist concluded, "I have yet to see any

(*Continued on Page* 162)

NEWS...

Rhatigan Is Named A.S.T.A. Secretary

Frank M. Rhatigan

CHICAGO.—Frank M. Rhatigan has been appointed secretary of the American Surgical Trade Association, Robert E. Anderson Jr., association president, announced several weeks ago.

Mr. Rhatigan, who has been sales promotion and convention manager of Davis & Geck, Brooklyn, N.Y., since 1946, has devoted the last 25 years to the field of medical and surgical supplies, and is a founder of the Medical Exhibitors Association, of which he is director of public relations. He has also served in officer capacities—one term as secretary of the association, and two terms as its president.

Connecticut Study Shows Who Pays the Hospital

NEW HAVEN, CONN.—Only 15 per cent of patient days in Connecticut's community hospitals were paid for by the patients themselves, according to a study completed by the Connecticut Hospital Association.

The association analyzed cases and patient days in the 34 general hospitals in the state for the year ending Sept. 30, 1952, and learned that Blue Cross in Connecticut absorbed the costs of 50 per cent of cases and 45.5 per cent of patient days.

The study also found that commercial insurance carriers paid 24.5 per cent of total hospital charges in both categories.

A.P.H.A. to Consider Community Needs

NEW YORK.—The 81st annual meet- of the American Public Health Association and annual sessions of 40 participating organizations will be held here November 9 to 13, the association announced last month. More than 5000 public health workers, including physicians, nurses, hospital administrators, health educators and others, are expected to attend the sessions, Dr. Reginald M. Atwater, executive secretary, said.

Theme of the meetings will be "Meeting the Health Needs of the Community," Dr. Atwater said.

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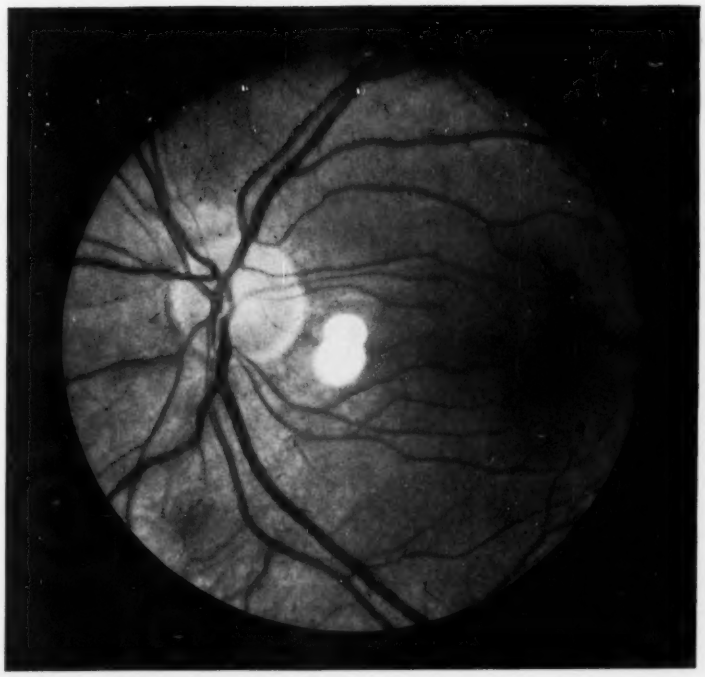

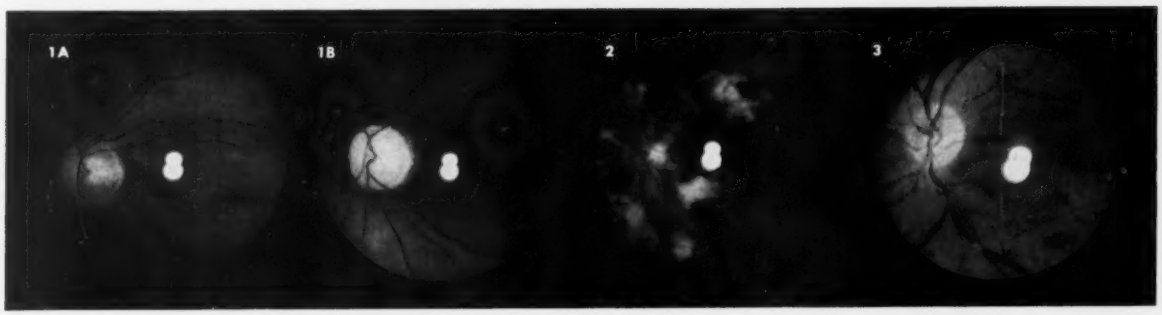

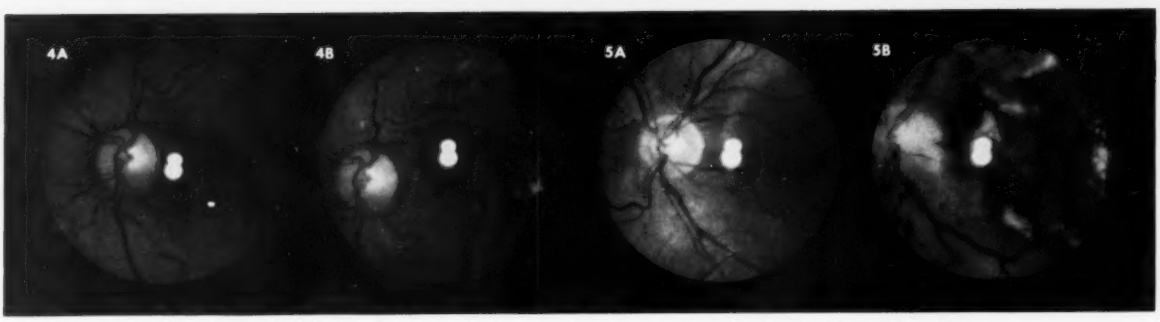

At top of page—Normal fundus oculi (×14). **1A**—Embolism central retinal artery. **1B**—Same case after four months, optic atrophy. **2**—Thrombosis central retinal vein. **3**—Hypertension arteriosclerosis. **4A**—Hypertensive retinopathy. **4B**—Same case after two years, showing venous and arterial changes. **5A**—Nephritic retinopathy. **5B**—"Cotton-wool" edema 26 months later.

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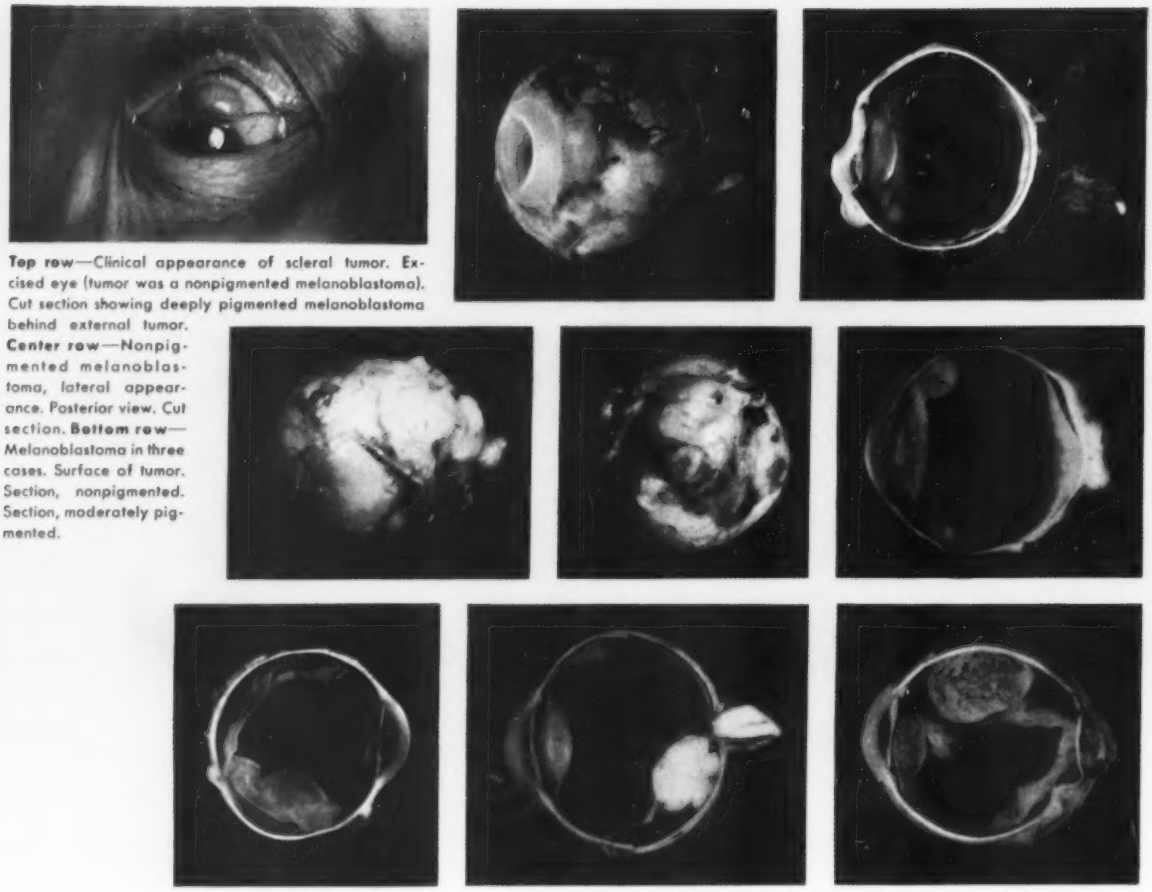

Top row—Clinical appearance of scleral tumor. Excised eye (tumor was a nonpigmented melanoblastoma). Cut section showing deeply pigmented melanoblastoma behind external tumor. **Center row**—Nonpigmented melanoblastoma, lateral appearance. Posterior view. Cut section. **Bottom row**—Melanoblastoma in three cases. Surface of tumor. Section, nonpigmented. Section, moderately pigmented.

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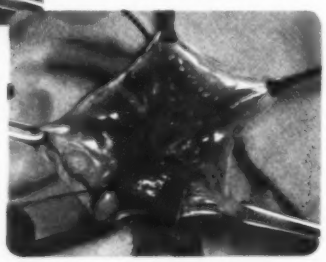

For motion-picture cameras. Kodachrome Film—16mm. rolls or magazines—permits duplicate prints in black-and-white or color.

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NEWS...

Nonclinical Specialists' Problems Are Weighed

(*Continued From Page* 158)

one of the so-called clinical specialists who is not happy and is not contributing a great deal to a group if he is paid on the same basis as the surgeon, internist, pediatrician and others. The way any physician works with his fellows depends on his own personality as well as those of his colleagues. A spirit of give and take, both from the standpoint of professional credit and of net income, is necessary. I believe that is all the nonclinical specialists desire."

Speaking for the specialty of radiology, Dr. Sidney F. Thomas of Palo Alto, Calif., said the failure of a radiologist to assume his rightful place on the staff may often be his own fault. "Failure is usually based on lack of clinical knowledge, not necessarily radiological knowledge," Dr. Thomas explained. "It may be that you don't do little things like putting his name on the films, which I think is important," he added. "These are incentive factors. They give him his name in lights, so to speak. I believe he deserves to get recognition for his technical merits as well as his ability to interpret the plastic with the emulsion on it.

"If the radiologist is not allowed to creep into the conversations, to be placed on the film, to be put into the minds of the patients right alongside the clinician, the clinician will eventually suffer too, because he will be dealing with an inferior radiologist. Enough in defense of radiology.

"What places in this country are there where the radiologist suffers badly? I don't know them. I haven't seen them. I haven't seen many radiologists being tramped on by the hospitals, but I am told in the East there are many places where the salaried positions are frequent, and in some groups that exploitation of the radiologist does take place because of the salary form."

ANESTHESIOLOGISTS' DISAFFECTION

Similar factors may enter into the disaffection of anesthesiologists, Dr. Clarence H. Walton of Urbana, Ill., told the group. First, he said, the anesthesiologist must have adequate assistance so that he may be used in a supervisory capacity and for problem cases rather than just for his ability as an anesthetist.

In addition, Dr. Walton continued, "operating room schedules must be planned in such a way that all of the anesthesiologist's time is not spent in the operating room. At least 40 per cent of his time should be available for consultations and patient rounds.

"Hospital staff meetings may serve as a clearinghouse for such grievances or conflicts as may occur between the various specialty groups. For example, a typical grievance of the anesthesiologist is the 'special permission' granted some surgical patients for arriving in the hospital the night before surgery instead of the afternoon before surgery, thus rendering more difficult the pre-operative preparation by the nursing staff and the anesthesiologist.

Referring specifically to the matter of financial arrangements between the specialist and the hospital, Dr. Thomas said: "I don't think the radiologist needs to be paid on the fee-for-service

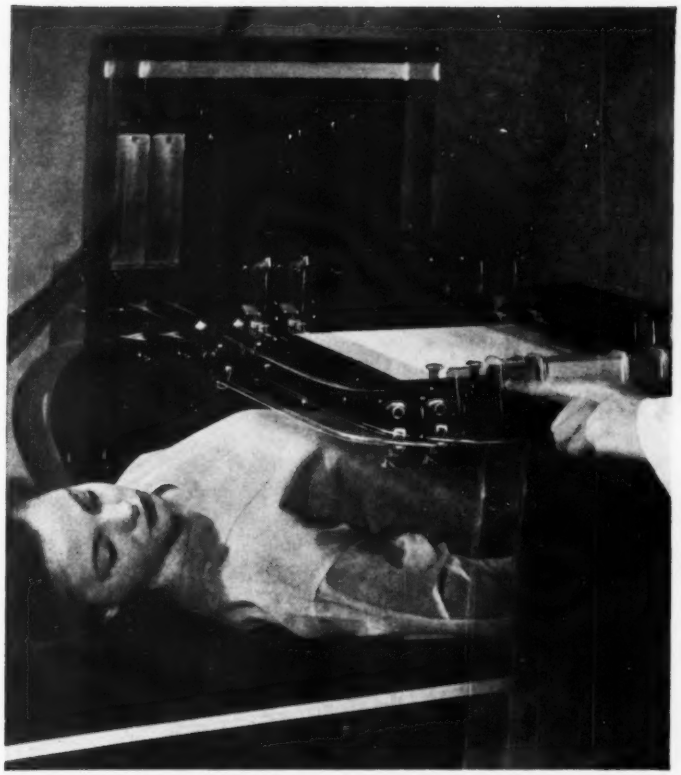
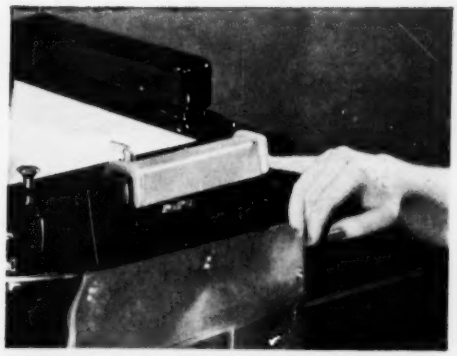


Photo shows fingertip control of screen and tower. Easy movement provides efficient and effortless operation for the radiologist.



Fingertip pressure unlocks and moves screen in one motion.

Action photo shows fingertip control with motion stopping smoothly.

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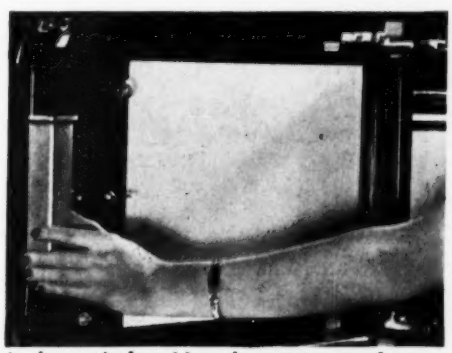

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NEWS...

basis. I think that ethical arrangements can be made with the hospital if the hospital is willing. If the hospital superintendents and the American Hospital Association come together and say—which they have already—'that is the way it is going to be; we are going to keep the radiologists, pathologists and anesthesiologists, all ancillary services in a salary bracket, and they are going to stay there as long as we are superintendents,' you cannot beat it. You cannot strike, because, if you strike, you strike at your patients, and that is an error.

"How would you work out a solution to the problem? I don't know how it could be done. I think the best way for these specialists is to set up an office and turn over their problem to the American College of Radiology, the American College of Pathology, whichever one they belong to, and see if they cannot prevent an ethical radiologist from slipping into that hospital after they leave."

Strep Infection Hits Long Island's Employes

NEW YORK.—Visitors were barred from Long Island College Hospital, Brooklyn, here last month when an epidemic streptococcal infection occurred among employes and staff members. Robert A. Hooper, personnel director, said that 60 doctors, nurses and employes were found to have the throat infection.

While several patients were discovered to have a mild form of the infection, Mr. Hooper reported, it was felt that precautionary measures instituted by the hospital would prevent spread of the disease to other employes and patients.

Correction

A news report on page 158 of THE MODERN HOSPITAL for August 1953 indicated that Sherlock, Smith & Adams of Montgomery, Ala., were architects for the Beckley Memorial Hospital, now under construction at Beckley, W. Va., as the first unit of the hospital system projected by the United Mine Workers of America Welfare and Retirement Fund. This was incorrect. Architect for the hospital at Beckley is Isadore Rosenfield of New York. Sherlock, Smith & Adams are architects for other hospitals in the U.M.W. group.

Wesley Memorial Hospital

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NEWS...

Welfare Reimbursements Raised in Massachusetts; Cost Division Started

BOSTON.—A hospital reimbursement bill raising state payments for welfare patients from $12 to $14 for the coming year was signed by Governor Herter here last month.

Sponsored by the Massachusetts Hospital Association, which named it the "Hospital Fair Play Reimbursement Measure," the bill becomes effective next January 1 for services rendered during the calendar year 1954, the association's newsletter explains.

The law also provides that the state commission on administration and finance shall establish a division on hospital costs and finances to supervise its administration.

For the period beginning Jan. 1, 1955, the new law provides that the director of hospital costs and finances shall determine from time to time the average, all-inclusive per diem charge to the general public for public ward accommodations or their equivalent, the all-inclusive per diem cost of care in such accommodations, and the all-inclusive per diem cost for all patients of each hospital licensed by the department of public health. Ancillary services shall be included in such cost determinations, it is stipulated.

The commissioner shall certify annually to every department, board or commission purchasing hospital care or reimbursing cities and towns for such care "such rates with respect to each such hospital as will reflect reasonable hospital costs or charges made to the general public, whichever is the lower," the law states.

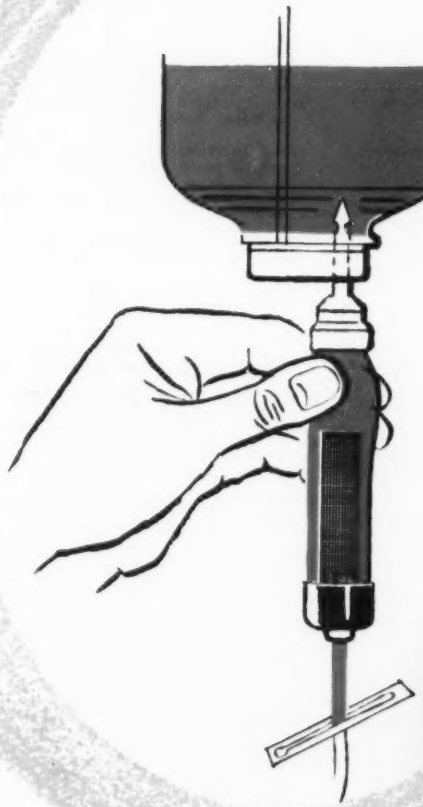
If the commissioner is unable to determine an all-inclusive per diem cost of care in public ward accommodations for any hospital, he may then certify an amount equal to 75 per cent of the all-inclusive per diem cost of care for all patients in the hospital. Such certification, however, is not to exceed $15 per diem, it is explained.

The bill also provides for establishment of a seven-member advisory committee, to be appointed by the governor, consisting of one certified public accountant, one hospital administrator, one hospital trustee, one representative of a purchasing government agency, and three representatives of the general public.

"The commission shall study the problems of hospital charges and costs and consult with the director of hospital costs and finances and with the commissioner of administration on all matters relating to the determination and certification of rates for hospitals," the law states.

Hospitals are required to furnish data, statistics or schedules on request to the commission. Failure to comply is punishable by fine. The director also has authority to examine books and accounts of any hospital.

"Passage of the bill marks a milestone in hospital reimbursement," the association's newsletter comments, "and at least in part will serve to correct an injustice of long standing which has contributed to the financial plight of many hospitals in Massachusetts. Passage of the bill now finally puts the matter of reimbursement to hospitals on the logical basis of the cost of such care to the hospital rather than on the basis of an arbitrary figure arrived at by legislative debate."



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Abbott A-C-D Blood container—A-C-D Solution, U.S.P. (N.I.H. Formula B), in the familiar Abbo-Liter® intravenous bottles, 500- and 250-cc. sizes. Blood is drawn (closed technique) directly into container by gravity. Available with Sodium Citrate 3% Solution in 500-cc. size. Also available with Donopak 24 and 48, with or without disposable needles. Designed for exclusive use with Abbott I.v. equipment.

For Storing Plasma:

Evacuated Empty Plasma Containers—Sterile evacuated 500- and 250-cc. Universal bottles for storing, transporting and administering plasma or serum.

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COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Palace Hotel, San Francisco, Oct. 5-9.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, 19th Annual Meeting, San Francisco, Aug. 29-31; Institute for Hospital Administrators, Chicago, Sept. 14-24; Southwestern Institute for Hospital Administrators, Houston, Tex., Nov. 16-20; Human Relations Conference, Montreal, Quebec, Nov. 23, 24; Human Relations Conference, Kansas City Mo., Dec. 7, 8.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 18-21.

AMERICAN SURGICAL TRADE ASSOCIATION, Hotel Statler, New York City, Dec. 13-15.

ARIZONA HOSPITAL ASSOCIATION, Annual Meeting, Hotel Adams, Phoenix, Nov. 19-21.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Mar Monte, Santa Barbara, Oct. 29, 30.

COLORADO HOSPITAL ASSOCIATION, Antlers Hotel, Colorado Springs, Nov. 19, 20.

FLORIDA HOSPITAL ASSOCIATION, Miami Beach, Dec. 1, 2.

ILLINOIS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Abraham Lincoln, Springfield, Dec. 1, 2.

ILLINOIS HOSPITAL AUXILIARIES ASSOCIATION, Hotel Leland, Springfield, Dec. 1, 2.

INSTITUTE ON DIETARY DEPARTMENT ADMINISTRATION, Park Sheraton Hotel, New York City, Oct. 26-30.

INSTITUTE ON HOUSEKEEPING, Somerset Hotel, Boston, Nov. 16-20.

INSTITUTE ON LAUNDRY, Park Sheraton Hotel, New York City, Nov. 9-13.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, St. Charles Hotel, New Orleans, Dec. 7-11.

INSTITUTE ON PURCHASING, Penn Sheraton Hotel, Philadelphia, Oct. 19-23.

INSTITUTE ON SUPERVISORY TRAINING, Edgewater Beach Hotel, Chicago, Nov. 2-6.

INTER-AGENCY INSTITUTE FOR FEDERAL HOSPITAL ADMINISTRATORS, Walter Reed Army Medical Center, Washington, D.C., Oct. 26-Nov. 13.

INTERNATIONAL CONSUMER CREDIT CONFERENCE, 40th Annual Meeting, Mark Hopkins and Fairmont Hotels, San Francisco, July 19-22.

KANSAS HOSPITAL ASSOCIATION, Lassen Hotel, Wichita, Nov. 12, 13.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Nov. 9, 10.

MISSISSIPPI HOSPITAL ASSOCIATION, Buena Vista, Oct. 14-16.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 19, 20.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 12, 13.

OREGON ASSOCIATION OF HOSPITALS, Hotel Benton, Corvallis, Oct. 22, 23.

WASHINGTON HOSPITAL ASSOCIATION, Olympic Hotel, Seattle, Sept. 30-Oct. 1.

1954

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 29-April 1.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TENNESSEE Hospital ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

Doctors Again Attack City Health Insurance Plan

NEW YORK CITY.—Operating changes in the prepayment medical and hospital care program of the Health Insurance Plan of Greater New York were proposed here last month by the Kings County Medical Society, which has charged that H.I.P. has been engaging in unethical practice.

The society proposed that H.I.P. initiate a contract which would permit the subscriber to go to his own doctor for medical care, instead of to a member of the H.I.P. group or panel, as at present.

Other changes proposed by the society were:

That H.I.P. should urge the city of New York to permit its employes to subscribe to any medical prepayment program, instead of only H.I.P., under the existing plan which provides for the city to pay half the subscription cost.

That H.I.P. urge the city to pay half the employes' premiums for hospitalization insurance, "whether or not they choose to have medical care insurance."

That practicing physicians "in adequate number" be designated by county medical societies for representation on the H.I.P. board of directors.

The society also charged the plan to "divest itself of any medical control function" by permitting subscribers to seek care from any medical group ready and willing to provide comprehensive service.

In a previous exchange in the long dispute between H.I.P. and local medical societies, Dr. George Baehr, president of the insurance organization, said that changes requested by the society would destroy the program and handicap hospitals and teaching institutions.

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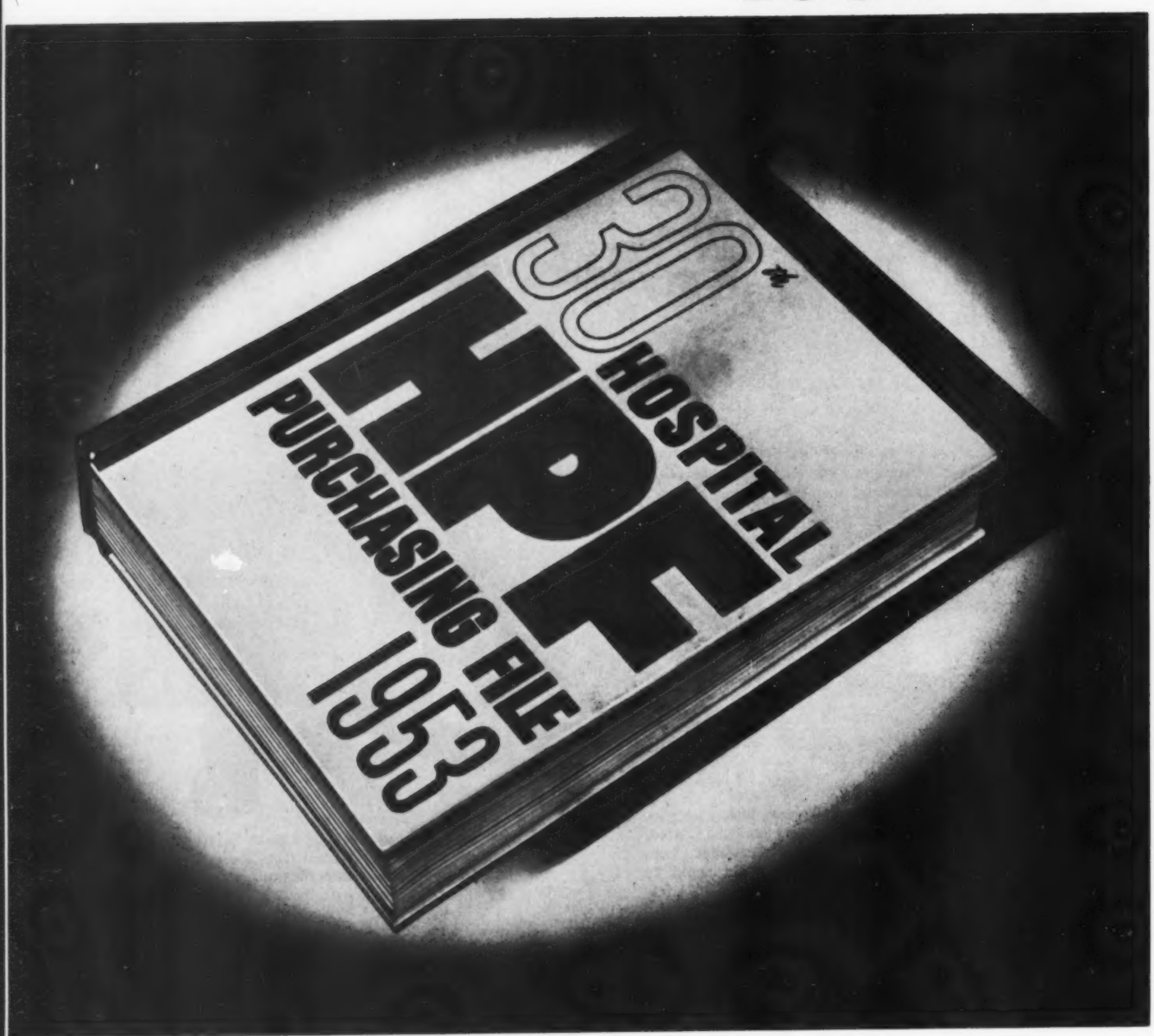

PROFESSIONAL EQUIPMENT

Professional equipment — the heart of hospital service — includes surgery, medical and nursing equipment, laboratory and diagnostic equipment, stills and sterilizers, and other related products. These are the things you buy most often. These are the things with which you are most familiar . . . but are you? When did you last explore new developments in this essential category? There is a wealth of information on these important items in the copy of Hospital Purchasing File now in your office. There are seven subdivisions of professional equipment and supplies. Three related sections are GA, GC and GD. Fifty-eight manufacturers have filed catalog information here for your use. How familiar are you with these catalogs? How familiar are your department heads with what is reported in this important section of Hospital Purchasing File? You will be better informed, you will buy more wisely if you make it a habit to turn to Hospital Purchasing File first. Look at the list on the right of the catalogs available in these three important sections.

Here are the catalogs in Sections GA, GC and GD

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American Wheel Chair Co., Inc.
Armstrong Co., Inc., The Gordon
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Gendron Wheel Co.
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International Equipment Co.
Jones Metal Products Co.
Koenigkramer Co., F. & F.
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Levernier Laboratories, Inc.
Linde Air Products Co., A Division of Union Carbide & Carbon Corp.
Liquid Carbonic Corp., The, Medical Gas Division
Market Forge Co.
Mueller & Co., V.
National Cylinder Gas Co., Medical Division
O. E. M. Corporation
Ohio Chemical & Surgical Equipment Co., A Division of Air Reduction Co., Inc.
Orthopedic Frame Co.
Oxygen Equipment & Service Co.
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NEWS...

Illinois Enacts Inclusive Hospital Licensing Law

CHICAGO.—A licensing bill that places most hospitals in the state under a licensing program administered by the state department of public health was passed just before the state assembly adjourned and was signed by Gov. Stratton on July 1.

The new law brings under one program the licensing of all general and specialized hospitals, tuberculosis sanatoriums, maternity homes, lying-in homes, and homes for unwed mothers in which care is given during delivery in the state. The only hospitals exempted in the language of the bill are state and private mental hospitals and psychiatric sections of general hospitals, which already are licensed by the department of welfare.

The bill repealed previous legislation providing for the licensing of maternity hospitals and hospitals that had received Hill-Burton grants, so that all hospitals would be under the one program.

Adapted from a model licensing bill, the act provides for the appointment of a hospital licensing board consisting of two members of hospital governing boards, three hospital administrators, and two practicing physicians, with each member to serve a term of three years.

The bill also provides that the director of the department give consideration to the recommendations of the "professional organizations concerned with hospital administration" in appointing administrator and hospital governing board members of the licensing board. It carries no appropriation for administration of the act. Since the department of public health originally asked $250,000 for this activity and since it is reported that the department is heavily committed to its present budget, it appears that the licensing program will be operated on a somewhat limited basis at least until 1955, according to the report.

City's Home Care Saves Millions in Construction

NEW YORK.—Its home care program is saving the Municipal Hospital Department the equivalent of $50,000,000 in new hospital facilities, Dr. Marcus D. Kogel, hospital commissioner, reported here last month.

Each day, according to Dr. Kogel's report, more than 2000 patients are

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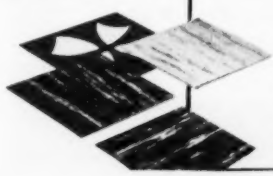

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receiving care in their own homes instead of in city institutions. At today's cost of $25,000 a bed to establish new facilities, he explained, the program thus results in a $50,000,000 saving to the city department.

Municipal hospitals are also less severely overcrowded than they were four years ago, when a peak of 100.8 per cent occupancy was reached, the report said. The citywide occupancy rate for 1952 was 96.4; seven hospitals had more than 100 per cent occupancy.

Occupancy for the first six months of 1953 was 94.7 per cent, the report said.

A construction and modernization program resulting in the addition of 3550 beds is now half completed, it was reported. So far, 3358 new beds have been opened, and 2127 in obsolete facilities have been eliminated, it was explained.

In addition, the hospital department has been transferring so-called custodial patients to private nursing homes under the broadened federal social security program for aid to disabled, the report said.

A.N.A. Aids Studies of Nursing Functions

NEW YORK.—Three grants totaling $25,775 have been made by the American Nurses' Association for studies of nursing functions, the association announced in July.

The department of sociology of the Wharton School of Finance and Commerce at the University of Pennsylvania received $11,625 to study the social-psychological characteristics of potential student and graduate nurses.

A grant of $11,800 was made to the Institute of Social Research, University of Missouri, for an investigation of the staff nurse in rural general hospitals of central Missouri.

The University of Arkansas received $2350 to study nursing functions in a 100 bed Arkansas general hospital.

The appropriations have been made to continue a research program begun in 1951.

New Law Governs Dental Care of Veterans

WASHINGTON, D.C. — Dental defects that appear within a year after discharge or separation from service are no longer presumed to have a service connection and to entitle the veteran to free care, the Veterans Administration announced here last month.

Under Public Law 149, signed by the President July 27, eligibility for outpatient dental care must be established under one or more of the following classes:

1. Veterans having service compensable dental conditions or disabilities, which means they must be rated 10 per cent or more disabling.

2. Veterans having service noncompensable dental conditions or disabilities in which the dental condition or disability is shown to have existed at time of discharge, or

3. Veterans having a dental condition, whether or not service connected, but medically determined to be aggravating a service physical disability or injury.

Veterans who qualify for treatment under these conditions may be referred either on a fee basis to "home town" participating dentists or to V.A.

ABOUT PEOPLE

(*Continued From Page 90*)

Methodist Church in Chicago. He has a degree in hospital administration from Northwestern University.

J. J. Strole, formerly of Renger Clinic and Hospital, Hallettsville, Tex., is now administrator of the Charles H. Ewing Memorial Hospital, Sinton, Tex.

Raymond C. Wilson, assistant superintendent of Southern Baptist Hospital, New Orleans, for the last several years, has been appointed the hospital's administrator. He succeeds **Dr. Frank Tripp** who will remain with the hospital and continue his supervision of a remodeling and modernization program.

V. Leslie Simmons, director of personnel, and **Robert F. Scates,** purchasing agent at Baptist Memorial Hospital, Memphis, Tenn., were named assistant administrators of the hospital. Mr. Simmons and Mr. Scates will continue to serve as head of their respective departments in addition to taking on administrative duties.

Milton H. Sisselman has been appointed administrative assistant of Mount Sinai Hospital, New York City, and **Harold A. Schneider** has been named administrative assistant for purchasing. Mr. Sisselman went to Mount Sinai last year as a Goldwater Fellow in hospital administration. He is a graduate of the Wharton school of finance and commerce, University of Pennsylvania, Philadelphia, and holds a master's degree in public health from Yale University. Mr. Schneider has been at the hospital for five years in a purchasing capacity. He holds a bachelor's and master's degrees from New York University.

Edwin F. Ross has been named assistant director of University Hospitals of Cleveland. He succeeds **H. E. Appleyard.** For the last four years, Mr. Ross was administrator of Doctors Hospital, Cleveland Heights, Ohio.

William J. Lees has resigned as administrator of Jefferson Hospital, Roanoke, Va., to accept a similar position at Memorial Hospital, Danville, Va.

Everett E. VanValkenburgh is the new assistant administrator at Symmes Arlington Hospital, Arlington, Mass. Mr. VanValkenburgh had been associated previously with Hartford Hospital, Hartford, Conn.

Dr. W. A. Sweatt has been appointed superintendent of Mississippi State Charity Hospital, Jackson, Miss. He succeeded **Dr. John W. Fristoe Jr.** on August 1.

David W. Morgan has been appointed assistant administrator of Birmingham Baptist Hospital, Birmingham, Ala. A graduate of the hospital administration course at Northwestern University, Mr. Morgan has just completed a year's administrative residency at Lloyd Nolan Hospital, Fairfield, Ala.

Arthur R. Traphagen, administrator of Riverside Community Hospital, Riverside, Calif., for the last 20 years, is retiring effective next January 1. However, Mr. Traphagen will serve as treasurer of the hospital's building fund.

Weir Richard Kirk, assistant administrator of Union Hosptial, Terre Haute, Ind., has been named administrative director of Riley County Hospital, Manhattan, Kan.

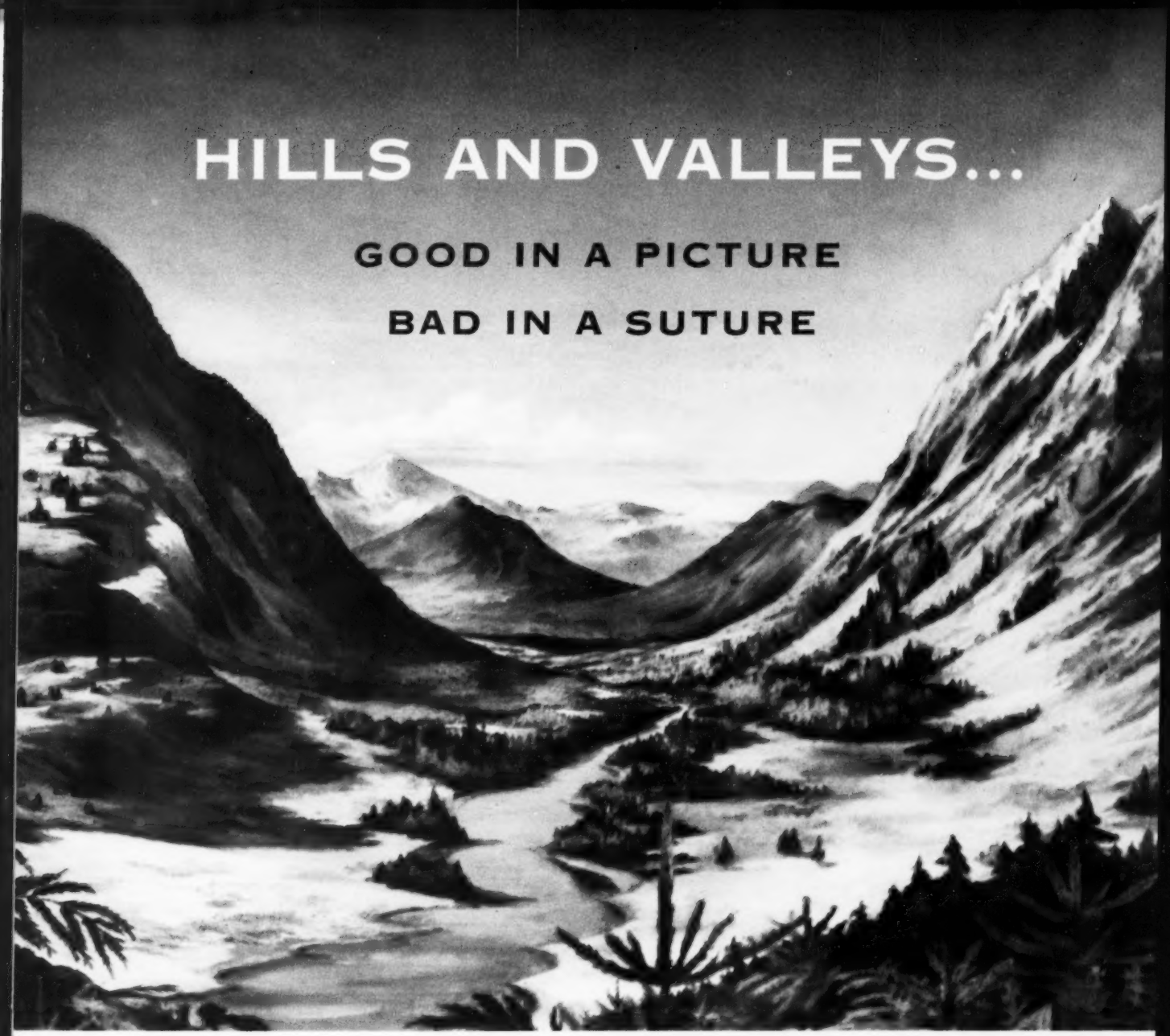
William N. Wallace has been appointed assistant director of the Charles T. Miller Hospital and Amherst H. Wilder Dispensary, St. Paul. On June 30, he received his master's degree in hospital administration from the University of Minnesota.

George H. Stone has resigned as superintendent of Salt Lake County General Hospital, Salt Lake City, Utah, to become director of John D. Archbold Memorial Hospital, Thomasville, Ga. He is a graduate of the course in hospital administration of the University of Minnesota and is a member of the American College of Hospital Administrators. He succeeds **William H. Thrasher,** director for the last three years, who has left to enroll in the hospital administration course at the University of Minnesota.

Leon C. Carson has been appointed assistant administrator of Citizens General Hospital, New Kensington, Pa. He was formerly administrative assistant at Robert Packer Hospital, Sayre, Pa. Mr. Carson received his degree in hospital administration from Columbia University and served his administrative residency at the Robert Packer Hospital.

Frederick W. Gradie has resigned as superintendent of Glens Falls Hospital, Glens Falls, N.Y., and **Dr. Morris Maslon,** the hospital's chief of staff, has been named his successor.

Maxine DuBois became superintendent of Comanche County Hospital, Coldwater, Kan., in July, succeeding



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Eathel Boyle. Mrs. Boyle has been superintendent of the hospital since it opened in August 1950.

Sister M. Magdalen has succeeded **Sister M. Agatha** as administrator of St. John's Hospital, Tulsa, Okla. Sister Magdalen has been a member of the supervisory staff of the hospital since 1936. From St. John's, Sister Agatha has gone to Holy Family Hospital, Estherville, Iowa, where she will take over her duties as administrator.

Wesley Burch, administrator of Stilwell Municipal Hospital, Stilwell, Okla., resigned to accept a similar position in Beaver, Okla., where a new hospital is under construction. **Gladys Bradley** of Franklin Hospital, Claremore, Okla., is his successor.

Homer Coggins, former businessman, has been named administrator of Choctaw County Memorial Hospital, Hugo, Okla., succeeding **James Foerster.**

Rinda F. Raines, administrator of King's Daughters' Hospital, Madison, Ind., has retired. Mrs. Raines had been with the hospital for 22 years.

George P. Goshorn, administrator of the Veterans Administration regional office of the medical division in Little Rock, Ark., has become administrator of Johnson County Memorial Hospital at Franklin, Ind.

Dr. Oreon K. Timm, chief of professional services at the V.A. Hospital in Danville, Ill., will take over as the hospital's manager on September 30, when **Dr. L. E. Trent** retires.

Richard A. Derr has been appointed assistant director of Niagara Falls Memorial Hospital, Niagara Falls, N.Y. Mr. Derr is a recent graduate of the hospital administration course at St. Louis University, St. Louis, and served his administrative residency at Niagara Falls Memorial.

Dr. George L. Wadsworth, chief of professional services at the V.A. Hospital in Tomah, Wis., succeeds **Dr. John L. Haskins,** manager of the V.A. Hospital at Roseburg, Ore. Dr. Haskins has been transferred to the V.A. Center at Los Angeles.

Elwood A. Opstad, assistant administrator of Englewood Hospital, Englewood, N.J., for the last three years, is now administrator of Huntington Hospital, Long Island, N. Y. He is being succeeded by **Frank Schwermin,** who had been executive officer of the Army Hospital at Scott Field, Ill. Mr. Schwermin is a graduate of the hospital administration course at Washington University, St. Louis.

Department Heads

Mrs. Wilhelmina K. Best has been appointed executive housekeeper at Faulkner Hospital, Jamaica Plain, Boston. Mrs. Best was assistant executive housekeeper at Muhlenburg Hospital, Plainfield, N.J., for the last six years. She succeeds **Anna F. Starbird,** who resigned recently after having been the hospital's housekeeper since 1929.


Alice Saar

Alice Saar, former director of medical service of the Chicago Welfare Department, will become director of the outpatient department of the Children's Memorial Hospital, Chicago, on September 15. Miss Saar has been associated with the Chicago Welfare Department since 1938, before which time she served as a social worker at Children's Memorial for three and a half years. Her bachelor of science degree was received from Knox

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Milwaukee

HAWAII
Honolulu, T. H.

College, Galesburg, Ill.; she also attended the school of social service administration at the University of Chicago. She is vice chairman of the medical care committee of the American Public Welfare Association and a member of the American Association of Medical Social Workers.

Edna W. Scott has been appointed director of nurses at Bryn Mawr Hospital, Bryn Mawr, Pa.

Margaret M. Heyman is the new director of social service at Albert Einstein Medical Center, Philadelphia.


Inez M. Salerno

Inez M. Salerno has become assistant director of nurses at Cleveland Clinic Hospital, Cleveland. Prior to accepting her new appointment, Miss Salerno was surgical supervisor at the Indiana Hospital School of Nursing, Indiana, Pa.

Lt. Col. Irwin J. Katz, MSC, has been named director of personnel at Walter Reed Army Medical Center, Washington, D.C. Col. Katz has been the center's assistant director of supply.

Dr. Harold J. Jacobs has been appointed director of the cardiac and pulmonary laboratories and also director of medical education at De Paul Hospital, Norfolk, Va.

Grace Decker, R.N., is the new educational director of St. Elizabeth Hospital and its school of nursing at Covington, Ky. Prior to this appointment, Miss Decker was educational director at Shannon Hospital, San Angelo, Tex.

Miscellaneous


William H. Markey Jr.

William H. Markey Jr., formerly accounting specialist on the staff of the American Hospital Association in Washington and Chicago, has joined the staff of the Catholic Hospital Association of the United States and Canada in St. Louis. Mr. Markey will assist member hospitals of the association in their efforts to improve financial management practice. Prior to joining the American Hospital Association several years ago, Mr. Markey was administrator of the Shadyside Hospital, Pittsburgh.

Dr. Clifton K. Himmelsbach has been appointed assistant chief, division of hospitals, of the U. S. Public Health Service. Formerly medical officer in charge of the U. S. Public Health Service Outpatient Clinic in Washington, D.C., he succeeds **Dr. Myron D. Miller. Dr. Stanley E. Krumbiegel,** medical director of the bureau of prisons, Department of Justice, since 1948, will succeed Dr. Himmelsbach.

J. L. Spore has been named confidential assistant to **Harvey V. Gigley,** administrator of veterans affairs of the Veterans Adminstration.

Dr. Edward H. Leveroos has been named to the newly created position of director of the division of hospitals and graduate education of the American Medical Association's Council on Medical Education and Hospitals.

Mercedes Marie Breen, instructor at the University of Nebraska School of Nursing, Omaha, for the last 22 years, retired on July 1.

Cleveland Rodgers has been named executive secretary of the Mid-West Hospital Association to succeed **Anne Walker,** who resigned July 1.

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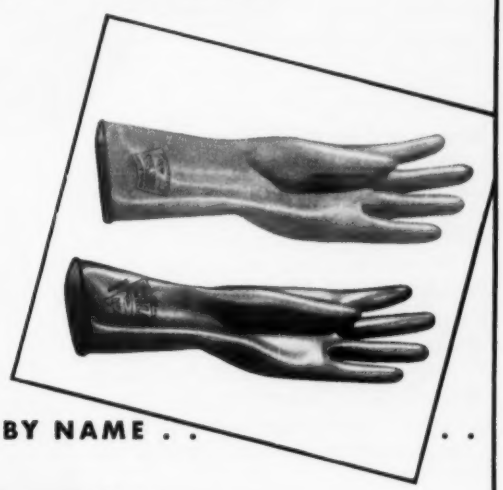

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Internal Control Methods on Linen, China, Glass

(*Continued From Page* 130)

five or more people access to their reserve supply of linens; two of these are small hospitals. About two-thirds of the hospitals reporting use requisitioning for stock withdrawals. The same percentage, but with 15 instead of 19 institutions answering, add stock returns back to the reserve-stock inventory. Of the institutions that price their requisitions, twice as many price by the average cost method than by the fifo (first in, first out) method. Only one hospital uses the lifo (last in, first out) method.

Inventories. Seventeen of the 19 hospitals replying inventory their linen reserve stock. The two that do not inventory are sizable hospitals which, also, do not keep perpetual inventories. Two-fifths of the 15 hospitals reporting on frequency of taking inventory say that they inventory yearly. About one-fourth inventory monthly; a fifth inventory twice a year. Eighty-two per cent of institutions reporting price their reserve stock inventory for financial reports. Three hospitals do not price their reserve stock inventory. Half of those that price use the cost method; the other half use the average cost method. Three of 16 hospitals responding depreciate their reserve stock inventory for financial reporting: one at 10 per cent; two others give no depreciation percentage.

Perpetual Inventory. Seventy-two per cent of responding hospitals maintain perpetual inventory records. This figure is 17 per cent less than that of hospitals taking physical inventories. More than half of 19 respondents use established minimum quantities of linens for reordering and make stock reconciliations to account for shortages resulting from damage and misappropriation.

The rotating system of linen stock controls, which takes care of reconciliation for shortages, is being used by seven hospitals. Four of these institutions are small; three are large. Audit checks of reserve stock inventories are made by two-thirds of the reporting institutions. More than half of those that make such a check audit only occasionally; a fourth, however, audit frequently.

Reserve Stock Replacement. Ten hospitals furnished a percentage relationship of yearly stock replacement to total reserve stock. Four of these ratios range from 5 to 10 per cent; three, from 11 to 35 per cent, and the remaining three, from 36 to 100 per cent. Two hospitals report a loss per patient day for stock depletion of one cent and 10 cents per patient day, respectively. The activity of the first hospital is about three times that of the second. Three hospitals do not have available, as yet, information for calculating the percentage of yearly stock replacement to total stock; several hospitals do not know their loss per patient day for stock depletion. About one-third of the responding hospitals use durability, average life and turnover data, resulting from the dating of linens. Such data influence purchasing and the size of stock. All answering hospitals conserve stock by remaking torn linens into other useful items.

In-Service Stock Controls. Approximately two-thirds of respondent hospitals inventory in-service stock, usually on a regular basis. In regard to the frequency of taking inventory, they report the same as was reported for reserve stock, namely, that two-fifths of their number inventory yearly.

Three hospitals depreciate in-service stock for financial reports. The respective depreciation percentages are: 10, 50, and 33⅓ the first year.

Almost two-fifths of 18 respondents establish minimum and maximum quantities for in-service stock. Withdrawals from stock because of depreciation or damage are controlled by 11 hospitals. Five of these use the rotating stock control system. One-third of replying hospitals make audit checks of in-service stock. These checks, in respect to frequency, are usually made occasionally.

CHINA, GLASSWARE AND SILVERWARE

Seventeen of 22 hospitals responding maintain reserve stocks for china, glassware and silverware. One hospital not maintaining reserves stated it had no space to store tableware stock. This hospital is small and is maintained for students. Fifty per cent or more of hospitals reporting for each type of stock have a proportion of reserve stock to in-service stock of less than one to one. There were more hospitals in this category for silverware than for glassware. This is typical since the rate of replacement is lower for silverware than it is for glassware. Furthermore, no hospital reported a large amount of reserve stock in comparison with in-service stock for silverware. The epidemic preparedness factor has no influence on the size of china, glassware and silverware reserves at 63 per cent of the responding institutions. A fourth of the respondents say they increase the normal size of tableware stock one and one-half times in order to be prepared for epidemics. Regarding the marking of stock, almost half of responding hospitals identify silverware whereas approximately one-sixth of them identify china. Only one hospital stocks marked glassware.

Central Storeroom. Sixty-eight per cent of hospitals replying maintain a central storeroom for china and silverware reserves. One hospital keeps glassware in a central storeroom. China and silverware reserves are placed in charge of a storekeeper by three-fourths of the answering hospitals. One hospital places glassware in charge of a storekeeper.

In respect to accessibility of employes to tableware stock, approximately one-fourth of the reporting institutions permit access of five or more persons to this stock. There is an increase in the percentage of hospitals giving only one person access to stock from china to silverware stock of 29 to 35 per cent. Thus, field practices indicate a small, progressive increase of control from china to new silverware.

Requisitions for tableware withdrawals are used by approximately two-thirds of the respondents. As in the case of linens, the average-cost method is used by twice as many hospitals as the fifo method for the pricing of requisitions. More than half of the reporting hospitals add stock returns back to the tableware reserves.

Inventories. Eighty-eight per cent of answering hospitals inventory tableware reserve stocks. One-half or more of hospitals reporting inventory yearly. A fourth, or less, inventory semi-annually. Four-fifths of the respondents price tableware inventories for financial reports; four hospitals depreciate the china inventory.

Perpetual Inventory. Fifty-three per cent of replying hospitals maintain perpetual inventory records for china, glassware and silverware reserves. Established minimum quantities for reordering purposes are used by more than half of the hospitals. Exactly

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half of the answering hospitals make reconciliations of tableware stocks to account for shortages because of damage, breakage or misappropriation. Audit checks of tableware reserves are made by about 50 per cent of institutions reporting. Most of the hospitals audit occasionally.

Reserve Stock Replacement. Nine hospitals gave a percentage relationship of yearly tableware stock replacement to total stock of from 0.5 to 100 per cent. There was an average of five hospitals for each type of stock in the range from 0.5 to 10 per cent; one hospital, from 11 to 35 per cent; three hospitals, from 36 to 100 per cent. One reporting hospital has 100 per cent stock replacement for each of the four stocks, linens included. This hospital is a large general hospital that maintains twice its normal size of stocks to take care of epidemics. The greatest number of high replacement percentages was tallied for glassware. The smallest number of low percentages was recorded for silverware. China replacement percentages fell almost midway between these extremes.

The foregoing is typical since glassware is highly breakable and silverware, at least in a nonhotel operation, is a fairly permanent stock. Three hospitals, because of newness of operation, do not have available the necessary information for figuring a replacement percentage.

In-Service Stock Controls. Fifty-six per cent of replying hospitals inventory tableware in-service stock. One-third of the answering hospitals inventory tableware in-service stocks yearly. There is some evidence of a greater frequency of inventory for them than for linen in-service stock. This fact is not significant, however, since minimum and maximum quantities are established at seven hospitals for linen in-service stock and at only four hospitals for tableware in-service stocks. Stocks requiring increases to their maximum limits are, as a matter of routine procedure, counted and checked frequently. Depreciation of in-service stock for financial reporting is done by two of the respondents. Control of withdrawals from tableware in-service stock is considered one-half as important as in the case of linens. Audit checks of in-service stocks are made by about a fourth of reporting hospitals. Two of four responding hospitals audit in-service stock yearly.

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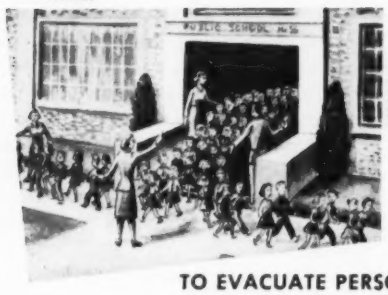
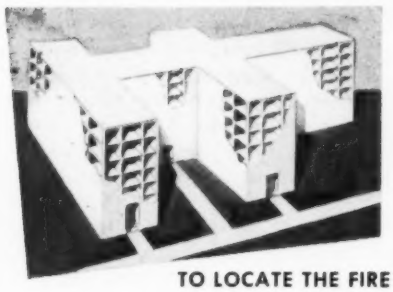


TO EVACUATE PERSONNEL



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Since the fire alarm requirements of a hotel differ widely from those of a school, a hospital, or an industrial plant, well planned fire alarm systems do more than just meet the requirements of the fire codes. They provide the type of service which will best protect the building, and those who occupy it. Basically, the three most important functions of a fire alarm system are: to evacuate personnel, to locate the fire, and to summon municipal fire fighting equipment. Couch Fire Alarms provide any one, or all of these functions, with special variations for unusual service.

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THE BOOKSHELF

FUNDAMENTAL RESEARCH IN ADMINISTRATION: Horizons and Problems. *Pittsburgh: Carnegie Press, Carnegie Institute of Technology,* 1953. $2.

Here is a new book which, if strategically placed in the hands of the leaders in the hospital field, would do much to crystallize present thinking in hospital administration. It is a small book, but it is anything but small in ideas. Those intrepid pioneers who early voiced the need for an Institute of Hospital Affairs and other research ventures will have a feast in devouring its contents.

The book represents the recorded expressions of a round table of some leading industrialists, business magazine editors, and faculty members from several important technological schools. They met not as "a crowd of fools gathered together to appear wise" but as a body of leaders seriously seeking answers to some of today's most pressing administrative problems. Reviewing the remarks made at this conference recalls to mind the late Otho F. Ball's admonition to "see the big picture." Indeed, he would have smiled approvingly at the whole tone of this meeting.

The conference was preceded by an address by Sidney A. Swensrud, president of the Gulf Oil Corporation, which dealt with some of the persistent problems of preparing men for top management posts and with the rôle of research in industry. Much of what Mr. Swensrud and those who followed him have presented finds a direct counterpart in hospital and medical care administration.

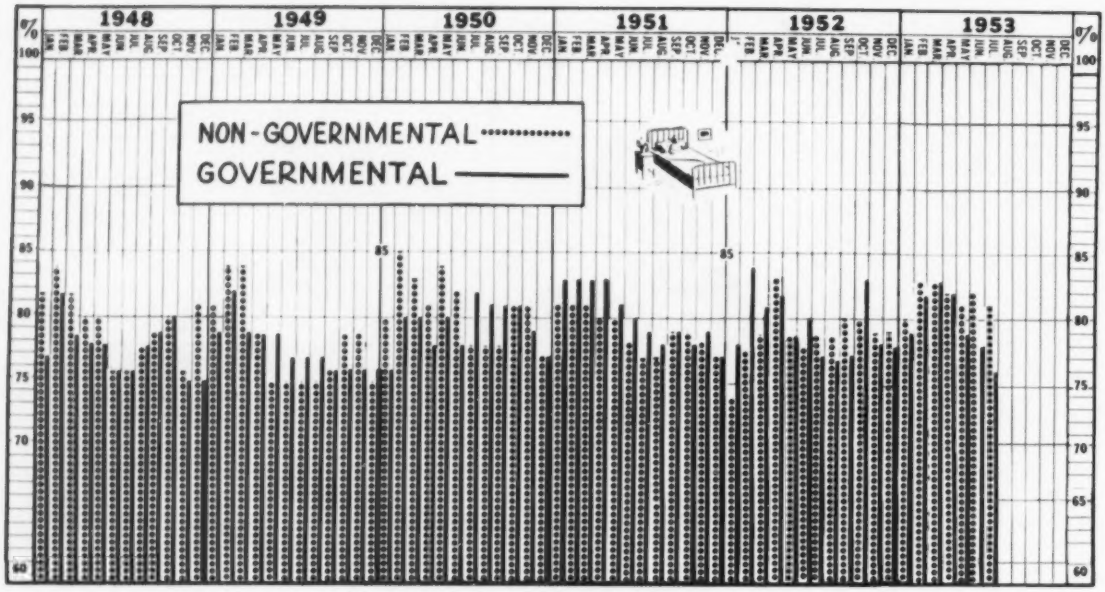
For the most part, past administrative research has been carried on largely in terms of surveying existing practices to discover what works well under what circumstances. What appears to be the "best" existing practice is then earmarked. This may be important, but it is not research in the sense formulated in this report. Research consists of going forth to new vistas and new horizons. Indeed, this type of activity may look as queer and as long-haired as atomic physics did a decade or so ago. But it may eventually pay off just as the work of chemistry, biology and physics has resulted in new products, new cures, and new processes.

Perhaps the most promising contribution of administrative research might well be its destroying the mythical validity of some of the axioms and aphorisms that have become rooted in our day-by-day administrative practices. Or, as one of the participants at the conference remarked, "The fact might be uncovered—a fact too little recognized by administrative experts generally—that the number of ways of skinning a cat successfully are many and varied, depending upon the man who does the skinning, and perhaps also on the particular cat being skinned."

In addition to the foregoing, virtually every other problem in this area is raised. Look over just a few of these and recall how many times you have either thought about them or discussed them: Why do some organizations fail? How can young men of great promise be identified early in their careers and exposed to wider administrative horizons? Where does the specialist or the "expert" fit into the picture? What is the rôle of the university in fostering or conducting research in administration? Does your existing organizational setup *really* produce results? What are the differences between fundamental and applied research? What is the rôle, if any, of each in administration?

Ivory-tower questions? Perhaps. But if you glance through this report you may be amazed to discover that at times the "doers" were a step ahead of the "thinkers" and the educators. True, the appeal to authority may be a weak argument. However, when the top management from companies such as B. F. Goodrich, Westinghouse Electric Corporation, Gulf Oil Corporation, and Pittsburgh Glass Company are univocal in pointing out the common problems and needs of management, it seems foolish indeed to dismiss the report as another example of idle speculation!—JOSEPH P. PETERS, *formerly hospital consultant, Division of Medical and Hospital Resources, Public Health Service.*

Projects Total 183; Cost Was $141,582,385



In their monthly reports to the Occupancy Chart, government hospitals have reported an average occupancy of 76.3 per cent and nongovernment hospitals an occupancy of 81.4 per cent.

Figures of a year ago indicate that government occupancy is at the same level this year as reported last July, but show a rise in the occupancy of voluntary hospitals over last year's percentage of 79.2.

Hospital construction for the year now totals $498,728,505. For the latest period ending August 10, 153 projects were reported at a cost of $141,582,385, the largest totals of 1953.

Among the current projects are 38 hospitals and 88 additions.

MAINTENANCE EXECUTIVES: New color chart will be mailed immediately upon request. Address: Pratt & Lambert-Inc., 126 Tonawanda St., Buffalo 7, N.Y. In Canada: 18 Courtwright St., Fort Erie, Ont.

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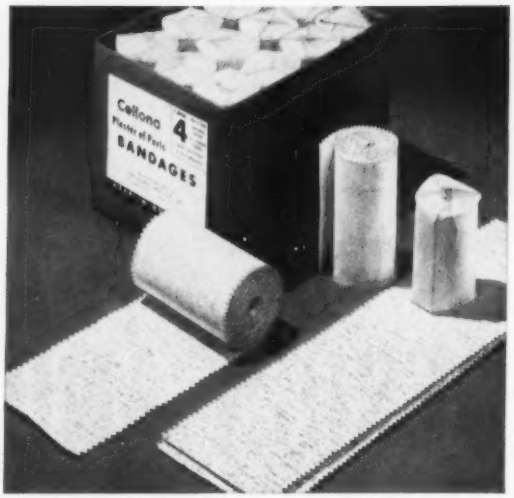

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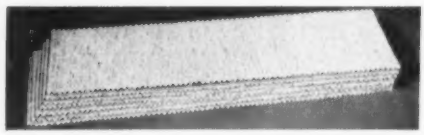
S365—4″ x 5 yds. Slow Setting	**S371—8″ x 5 yds.** Slow Setting



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S374—4″ x 15″—50 per box—Fast Setting
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ADMINISTRATOR—Medical; four years experience, assistant, large municipal hospital; one year experience, superintendent, 170-bed tuberculosis hospital; member A.H.A.; age 37, married, family. MW 8, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR — Male; college degree; three years during expansion, 50-bed hospital; seeks administration 100-150 bed hospital; available May, 1954. Write, MW 16, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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LIBRARIAN—Medical record, registered; registered nurse; capable, good personality; seeks hospital or clinic work in congenial atmosphere; minimum $300; east or west coast. Reply, MW 18, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PATHOLOGIST—Board Certified; 41; trained well known hospital; director hospital laboratory 12 years; desires change to hospital about 150 beds; east or west mountain area or southwest. Reply, MW 15, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

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ADMINISTRATOR—M.S., Hospital Administration; administrative residency, teaching hospital; four years, assistant administrator, 400-bed hospital; age 35; military duty completed.

ADMINISTRATOR—Medical; sixteen years, administrator, large teaching hospital during which time, for seven years, served as professor, hospital administration; FACHA.

ADMINISTRATOR—B.S., Nursing Education; Master's, Hospital Administration; six years, director of nursing, 150-bed hospital; two years, assistant administrator, 225-bed hospital.

RADIOLOGIST—Diplomate; M.S., Radiology; four years, associate radiologist, large teaching hosptial, on faculty medical school.

PATHOLOGIST—Diplomate; training in pathology, Johns Hopkins; seven years, director, pathology, teaching hospital, on faculty medical school.

MEDICAL BUREAU—*Continued*

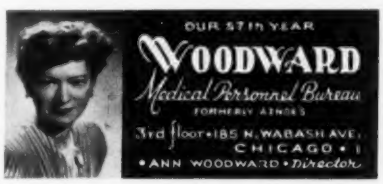
SOCIAL WORKER—M.S., Social Work; nine years, director, social service department, 400-bed hospital.

BIOCHEMIST—Ph.D.; three years' teaching; four years, biochemist and assistant director laboratories, 400-bed hospital.

PHARMACIST—B.S. in Pharmacy; five years, staff pharmacist, teaching hospital.

RECORD LIBRARIAN—A. B.; six years, chief record librarian, 400-bed hospital.

PERSONNEL DIRECTOR—B.S.; six years, personnel director, large industrial company; three years, personnel director, 300-bed hospital.



ADMINISTRATOR—Master's, Public Health; (Hospital Administration); Johns Hopkins; male graduate nurse; 4 years, head nurse, 1000-bed hospital; 5 years, administrator, general hospital, 100 beds; middle 30's; nominee, ACHA.

ADMINISTRATOR—Medical; three years, assistant director, university hospital; six years, director, outstanding medical center; FACHA.

ADMINISTRATOR — Graduate nurse; excellent experience includes fund raising; eight years, administrator, voluntary general hospital, 400 beds; adroit in public relations; FACHA.

PATHOLOGIST—B.S., M.S., M.D., eastern school; Certified, pathologic anatomy; eligible, clinical pathology; residencies, university hospitals; 2 years, pathologist, chief pathologist, USAMC; completing military tour; DNB; middle 30's.

RADIOLOGIST — Diplomate, both branches; trained university hospital; AOA; past year, associate radiologist, general hospital, 400 beds; seeks hospital, association or private practice with part-time teaching; early 30's.

INTERSTATE MEDICAL PERSONNEL BUREAU

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ADMINISTRATOR—M.H.A. Degree, 1947; 2 years, assistant administrator, 400-bed hospital, Massachusetts; present position, 4 years, administrator, 350-bed hospital; desires change.

ADMINISTRATOR — Or business manager; B.S. Degree, Business Administration; M.B.A. Degree, 1949, University of Chicago; 4 years, administrator, 450-bed hospital; west or midwest considered.

(Continued on page 196)

INTERSTATE—*Continued*

BUSINESS MANAGER—Age 44; Degree in Accounting; 9 years, assistant manager, 275-bed Pennsylvania hospital; 8 years, 250-bed hospital, New York.

EXECUTIVE HOUSEKEEPER—B.S. Degree, Home Economics, Ohio State University; 7 years, housekeeper, 300-bed eastern hospital; 5½ years, 250-bed hospital, south; excellent recommendations.

PERSONNEL DIRECTOR—B.S. Degree, Industrial Psychology; M.S. Degree, Administration; 18 months, personnel manager, 1000-bed hospital.

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ANESTHETIST — 200-bed AMA and ACS approved general hospital; new and modern; department headed by anesthesiologist; salary open, dependent upon experience. Write: B. W. Mandelstam, M.D., Administrator, Mount Sinai Hospital, Minneapolis, Minnesota.

ANESTHETIST—Nurse; for 240-bed hospital; salary open; partial maintenance provided. Apply, Administrator, Charleston General Hospital, Charleston, West Virginia.

ANESTHETIST — Nurse; well qualified; to work with clinic group; salary open, based on experience; all types of surgery; two hospitals associated with group, with total capacity of 150 beds. Carbondale Clinic, Carbondale, Illinois.

ANESTHETIST—Nurse; for 300-bed general hospital; midwest industrial city; A.C.S. and A.M.A. approved; modern facilities; comfortable living accommodations; paid vacation; pleasant working conditions. Apply: Administrator, Mercy Hospital, Hamilton, Ohio.

ANESTHETIST—Nurse; excellent opportunity 102-bed general hospital. Write or phone Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

ANESTHETIST—Nurse; needed by a 200-bed general hospital; air-conditioned surgery; pleasant environment; service not heavy; salary open. If interested, contact Administrator, Washington County General Hospital, Greenville, Mississippi.

ANESTHETIST — Nurse; modern 115-bed, acute general hospital; department in charge of certified medical anesthetist; salary open. For particulars, write Director, Department of Anesthesiology, Mount Sinai Hospital, Hartford, Connecticut.

ANESTHETIST—Nurse; one vacancy available in modern Westchester hospital, half hour from New York; excellent surgical staff; pleasant living quarters; schedule shared with two other nurse anesthetists allows liberal time off; chief of department outstanding diplomate in anesthesiology, constantly available for consultation; salary open. Write, MO 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; for an old established group; good starting salary and permanent position. The Sugg Clinic, Ada, Oklahoma.

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ANESTHETIST—Nurse; for 250-bed hospital, well equipped and fully approved, predominantly surgery; top salary, meals and laundry furnished; good hours; sick leave, vacation and holidays. Apply, Administrator, Mid State Baptist Hospital, Nashville, Tennessee.

ANESTHETIST—Nurse; St. Paul, Minnesota; conveniently located 400-bed hospital; pleasant working conditions; new, well-equipped operating room suite; good personnel policies; staff of 2 anesthesiologists and 7 anesthetists; salary open. Charles T. Miller Hospital, 125 West College, St. Paul 2, Minnesota.

ANESTHETIST—A.A.N.A. member; 250-bed general hospital; salary open; automatic increases; laundry provided; 40-hour week; no obstetrics; liberal vacation and personnel policy; social security. Sutter Hospital, Sacramento, California.

ANESTHETISTS—Three; immediate openings available; located in New York City; all types of surgery (no obstetrics); salary $4800-$6000 per year; 1 month vacation at end of each year; 2 weeks sick leave per year; quarters available in residence, $425 annually. Apply, The Roosevelt Hospital, 428 West 59th Street, New York 19, New York.

ANESTHETISTS—Nurse; two; for new 130-bed hospital; salary $350 to $400 and full maintenance, based on experience. Apply to: Administrator, Pitt Memorial Hospital, Greenville, North Carolina.

ANESTHETISTS—Nurse; attractive openings immediately available at modern 324-bed general hospital with active up-to-date anesthesia department; pleasant working conditions; interesting salary in addition to complete maintenance; generous vacation, sick leave, and holiday allowances; unusually good opportunity for those seeking permanent positions in a well-established department. Apply to Director, Eastern Maine General Hospital, Bangor, Maine.

ANESTHETISTS—Immediate openings available: A.A.N.A. members, two nurse anesthetists needed; obstetric anesthesia in a very active department with 350 to 400 deliveries monthly; eight hour rotating shifts; $350 a month beginning salary with room and laundry; 50 per cent of anesthesia fee per case for second call; social security; very pleasant working conditions. Apply, Administrator, Good Samaritan Hospital, Dayton, Ohio.

ANESTHETISTS—Nurse; for 500-bed university teaching hospital; starting salary $383 per month; stated increases; vacation and holiday leave; cumulative sick leave. Apply: Anesthesiologist in Charge, University of Virginia Hospital, Charlottesville, Virginia.

DIETITIAN — Associate, with minimum of three years' experience in administrative and therapeutic dietetics; immediate opening in 200-bed general hospital located in suburban town close to Chicago; $350 per month, plus complete maintenance for ADA member. Write full particulars about yourself to Miss M. Schoenecik, Memorial Hospital, Elmhurst, Illinois.

DIETITIAN — September opening for therapeutic dietitian; 250-bed hospital, central Connecticut; includes formal and clinical teaching; approved school of nursing. Reply, MO 43, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

(Continued on page 198)

classified advertising

POSITIONS OPEN

DIETITIAN—Chief; A.D.A.; experience preferred; for 350-bed hospital; responsible for supervision of dietetic department and for instruction in nutrition and diet therapy in school of nursing; salary commensurable with training and experience; excellent working and living conditions. Apply to The Superintendent, Mississippi Baptist Hospital, Jackson, Mississippi.

DIETITIAN—Chief; modern general hospital in San Francisco; should be thoroughly experienced with high degree of managerial ability; must be flexible and interested in developing or adopting new methods; prefer younger person. Contact Director of Personnel, Mount Zion Hospital, San Francisco, California.

DIETITIAN—For complete charge of dietary in 100-bed hospital; city of approximately 20,000 immediate urban population; good salary, open, with or without maintenance; school of nursing requires ADA membership. Contact Fred E. McEntire, Administrator, Lock Haven Hospital, Lock Haven, Pennsylvania.

DIETITIAN—Registered; for 100-bed hospital close to New York City. Apply to Administrator, Rahway Hospital, Rahway, New Jersey.

DIETITIAN — Staff; 165-bed private general hospital with young staff; conveniently located in medium-sized city; prefer ADA membership; no experience necessary; some therapeutic and some administrative work on staff of three; 40-hour week; newly remodeled kitchen; salary open, meals, laundry, insurance furnished. Apply, Personnel Director, Flower Hospital, Toledo, Ohio.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIRECTOR—Assistant; school of practical nursing; Degree in Nursing required, administrative experience preferred; 2 classes of 30 students per year; duties include teaching nursing arts; 300-bed general hospital; position open now; Registered nurse needed also. Apply, Director, School of Practical Nursing, Columbus City Hospital, Columbus, Georgia.

DIRECTOR—Educational; suburban Philadelphia; new school building under construction, expanding from 50 to 100 students. Apply, Administrator, Montgomery Hospital, Norristown, Pennsylvania.

DIRECTOR OF NURSING—350-bed hospital with school of nursing, averaging 200 students; this position would include responsibilities for both nursing service and education with necessary assistants in both departments; salary will be commensurable with experience and preparation; school of nursing has college affiliation and is open for further development; excellent opportunity in the atmosphere of a Christian hospital. Apply to The Superintendent, Mississippi Baptist Hospital, Jackson, Mississippi.

DIRECTOR OF NURSES—Assistant; in a 441-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience; maintenance and apartment included. Apply to Director of Nurses, Delaware Hospital, Wilmington, Delaware.

DIRECTOR OF NURSING SERVICE—25-bed approved maternity hospital; 44-hour, 5-day week; good personnel policies; excellent living accommodations if desired; salary open. Booth Memorial Hospital, 1881 Torbenson Drive, Cleveland 12, Ohio.

DIRECTOR OF NURSING SERVICE—Assistant; for 290-bed general hospital with nursing school; personnel policies include 44-hour week; 21 days vacation; 6 paid holidays; social security; Blue Cross; degree and experience required; salary open. Apply, Director of Nursing, Lima Memorial Hospital, Lima, Ohio.

(Continued on page 200)

classified advertising

POSITIONS OPEN

DIRECTOR OF NURSING SERVICE—Assistant; for Good Samaritan's Episcopal sponsored hospital of 400 beds; salary open; degree and experience required; excellent personnel policies. Apply, Director of Nursing, Good Samaritan Hospital, Portland 10, Oregon.

FOOD SERVICE DIRECTOR — For a 250-bed hospital located in a midwest city; must be experienced in planning meals, supervising kitchens, personnel, and analyzing costs; good working conditions and pleasant surroundings; salary open, depending on qualifications and experience. Reply, MO 42, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR-SUPERVISOR — Clinical; operating room; postgraduate and/or degree preferred; individuals with teaching and supervisory experience will be considered; excellent personnel policies, including 40-hour week, 6 paid holidays, social security, 6-month increments, 28 calendar days (20 working days) vacation. Apply, Director of Nursing, St. Luke's Hospital, Toledo 10, Ohio.

INSTRUCTOR—Clinical; for medical and surgical nursing; degree and experience required. The Toledo Hospital School of Nursing, North Cove Boulevard, Toledo 6, Ohio.

INSTRUCTOR - SUPERVISOR — Clinical; medical-surgical nursing; small school with three clinical affiliations—psychiatry, tuberculosis and pediatrics; excellent personnel policies, including 40-hour week, 6 holidays, social security, 6-month increments and 28 calendar days (20 work days) vacation; degree and supervisory experience necessary. Apply, Director of Nursing, St. Luke's Hospital, Toledo 10, Ohio.

INSTRUCTOR—Nursing arts; for 290-bed hospital; 120 students; three clinical affiliations—tuberculosis, psychiatry and pediatrics; temporary accreditation by National Nursing Accreditation Service; 44-hour week, 6 paid holidays, social security, 21 days vacation; degree and experience necessary; salary open. Apply, Director of Nurses, Lima Memorial Hospital, Lima, Ohio.

INSTRUCTOR—Nursing arts; for 192-bed hospital, 70 students; immediate opening; new educational department under construction; salary open. Apply to Director of Nursing, House of the Good Samaritan, Watertown, New York.

INSTRUCTOR—Nursing arts; school of 80 students, 316-bed hospital; liberal personnel policies; salary open; applicant should have had experience in teaching this subject; prefer someone with a degree. Apply to Jennie A. Baker, R.N., Director of Nursing, Mansfield General Hospital, Mansfield, Ohio.

(Continued on page 202)

INSTRUCTOR-SUPERVISOR — Obstetrics; to reorganize 40-bed unit, small school with psychiatric, pediatric and tuberculosis affiliations; excellent personnel policies including 40-hour week, 6 paid holidays, 28 calendar days (20 work days) vacation, social security, hospitalization; degree and experience preferred. Apply to Director of Nursing, St. Luke's Hospital, Toledo 10, Ohio.

INSTRUCTORS—Clinical, in nursing education; psychiatric affiliate program for student nurses in nationally recognized 1500-bed teaching hospital; require B.S. or M.S. in Nursing Education plus 4 years experience in psychiatric nursing, of which 3 were in a supervisory and teaching capacity; salary commensurate with qualifications and experience; periodic salary increases based on merit; vacation, sick and retirement benefits. Apply, Topeka State Hospital or Kansas Department of Civil Service, Topeka, Kansas

INSTRUCTORS — Clinical; for formal and clinical teaching; 465-bed hospital, 250 students; faculty being increased; teaching load light; salary $3624 to $4224; thirty-one days vacation; hospital has retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital in beautiful 40-acre park. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

Remington Rand Methods News

Have you seen . . .

The latest ideas in Remington Rand Office Equipment and Systems created to help you administer your hospital work with greater ease, greater speed and efficiency? They have all been tested and proved extremely effective in both large and small hospitals throughout the country. These and many other time and work-saving ideas are also on display at your local Remington Rand Business Equipment Center all year 'round.

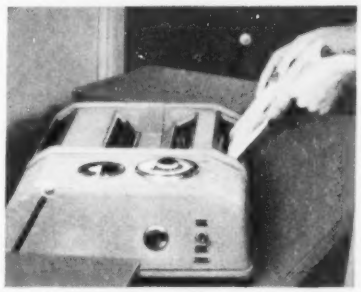
New low-cost bookkeeping machine

This new, complete machine, provides all the speed and efficiency of mechanized bookkeeping at only a fraction of the purchase price of other machines with similar features. It's the perfect bookkeeping machine for cost-conscious administrators of small and medium-sized hospitals—perfect for patients' statements, complete ledger, accounts payable, payroll and inventory accounting to name just a few hospital records. And any competent typist with elementary knowledge of bookkeeping can start full operation of this machine as soon as it's installed.

Entries to related records are made simultaneously. Each is neat, fully descriptive. Account Balances are computed and proved mechanically. Write for free booklet **AB593**, which describes how this low-cost machine helps keep complete patients' records, simplifies auditing and eliminates delays at the discharge desk.

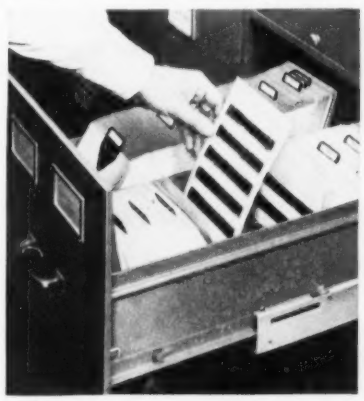
Speed up admission procedures

Remington Rand Manifold Admission Forms give each interested department in your hospital a complete, legible record minutes after a patient is admitted. Use the Remington Electric Typewriter to prepare these handy forms, to assure quick, easy typing and up to 15 crystal-clear carbon copies. Send for folder **SN615** and see how Manifold Admission Records may be used in your hospital. Samples of Manifold Admission Records are also available upon request.



By all means . . .

Be sure to see the new, instant way to make photocopies—The Remington Rand Transcopy Duplex. You don't have to employ busy clerical help to copy case histories for insurance transcripts and compensation cases any longer. Just plug this single unit machine into any standard electrical outlet and obtain photocopies of high fidelity, up to 14½" wide and any length. The entire procedure takes only seconds. Details are in free folder **P344.**



One way to keep your medical record library in order

Microfilm your valuable records. You'll find patients' case history records faster, gain needed floor space and provide better preservation of records as well. They may be filed on reels or in Remington Rand Kard-a-Film cards. Each card contains the complete patient's case history for easy reference. And you can utilize your present filing cabinets to house Kard-a-Film. Ask for free folders **F299** and **F262.**

Remington Rand has a complete line of microfilming equipment and readers for *rent* or sale to any size hospital. However, if you prefer, you needn't invest a penny in microfilming equipment. A staff of Business Services experts will microfilm your records, on or off your premises, using Remington Rand Equipment. The whole story is in free folder, **BSD5A.**

What's new in shelf filing?

If you're looking for a more efficient type of shelf filing, Remington Rand has the answer. It's our Divider Type Steel Shelving designed to house patients' case history records. Many hospitals throughout the country have installed this new type of shelf filing and find it easy to use, economical and a space-saver. The shelving is adjustable for expansion and can be removed without the use of tools. Misfiling is reduced to a minimum and easy reference assured with the easy-to-adapt Terminal Digit Tinting and Blocking Scheme for this file originated by Remington Rand. A detailed explanation of this system will be loaned to those who write in for **MC817.**

Seal of protection for vital records

You should protect your valuable patients' records, narcotics records and financial accounts from destruction by fire at point-of-use with Remington Rand insulated equipment. Extensive tests have been conducted on insulated desks and file trays to *certify* that this equipment will protect contents for specified periods from the ravages of fire ranging to temperatures of 1850°F. Fire insurance won't preserve your hospital records—*insulated equipment will.* Write today for free folder **SC684.**

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H-5

classified advertising

POSITIONS OPEN

INSTRUCTORS—Nursing arts instructor and Clinical instructor; 225-bed hospital; 90 students, 3-year course; 30 students admitted each year; insurance plan; social security; liberal vacation; degree required; salary arrangements open for negotiation; travel allowance. Apply Director Nursing Education, or Administrator, Bismarck Hospital, Bismarck, North Dakota.

LIBRARIAN—Medical record, registered; for 250-bed hospital with large outpatient department; salary open. Contact Children's Hospital, Washington 9, D.C.

MISCELLANEOUS — Educational director; Supervisor, medicine and surgery; General duty nurses; in a 350-bed general hospital; a copy of personnel policies will be sent on request. Apply, Director of Nursing, Sibley Memorial Hospital, Washington, D. C.

MISCELLANEOUS—Pediatric supervisor and Pediatric nurse; for 125-bed hospital, new addition in process; 44-hour week; salary open. Apply, Director of Nursing, Anniston Memorial Hospital, Anniston, Alabama.

MISCELLANEOUS—Assistant director of nursing, Supervisors, Staff nurses, for new ultramodern 200-bed hospital, opening in the near future in San Francisco; basic salary for staff nurses $275.60, for a 5-day, 40-hour week, with automatic increases; $10 additional for P.M. duty, and $15 additional for night duty; differential pay for operating and delivery room duty; opportunities for group clinic nursing; 2 weeks vacation, 7 holidays with pay, and 12 days sick leave annually. Apply, Director of Nursing, Kaiser Foundation Hospitals, 515 Market Street, San Francisco, California.

NURSE—Registered, qualified; female; for night supervision; salary range $250 to $275; excellent working conditions. For further information, write, MO 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—General nursing superintendent in Detroit area hospital; salary range: $6348-$7141 for 40-hour week; Bachelor's Degree including or supplemented by courses in nursing administration or education; graduate of a recognized school of nursing; minimum of 5 years professional nursing, at least 2 of which must have been as director or assistant director of nursing service in a hospital of at least 150 to 200 beds; paid vacations, sick leave, automatic annual salary increases. For application or information, write: Wayne County Civil Service Commission, 2200 Cadillac Tower, Detroit 26, Michigan.

NURSE—Registered; for surgery; 40-hour week; salary $12.75 to $13.75 per day. Apply, Director of Nurses, Clinton Memorial Hospital, St. Johns, Michigan.

NURSE—Assistant to psychiatric nursing superintendent in Detroit area hospital; salary range: $5554-$6034 for 40-hour week; Bachelor's Degree plus minimum of 2 years in psychiatric nursing with administrative experience; paid vacations, sick leave, automatic annual salary increases. For application or information, write: Wayne County Civil Service Commission, 2200 Cadillac Tower, Detroit 26, Michigan.

NURSES—General duty; communicable disease hospital, convalescent hospital, and tuberculosis sanatorium (separate institutions) in Michigan resort area; beginning salary $3000 plus maintenance; comprehensive employee benefit program. Reply, furnishing resume of training, experience and personal background: Oakland County Personnel Office, 1 Lafayette Street, Pontiac, Michigan.

NURSES—General duty; for 650-bed teaching hospital in central California; salary $273-320 per month; 40-hour week; liberal vacation, holiday and sick leave plan. Apply, Personnel Office, 510 East Market, Stockton, California.

NURSES—General duty; 300-bed general hospital; nurses' home; 40-hour week; starting salary $260 per month, plus one meal; $10 monthly extra for 3-11, 11-7 shifts, tuberculosis, obstetrical, surgical and isolation; Canadian nurses need passport and visa. Write, Director of Nurses, Merced County General Hospital, Merced, California.

(Continued on page 204)

One case of Rondic Sponges frees a nurse for two 8-hour days

. . . and costs less than sponges made by your own personnel

Even the most skillful nurse can make no more than 4 "cherry" sponges per minute by hand. Theoretically she could make 4000 in two 8-hour workdays.

But a case of 4000 uniformly machine-made RONDIC Sponges costs far less than the labor and materials for "rolling your own."

RONDIC Sponges handle easily in forceps, do not stick together. They are cotton-filled, gauze-wrapped, with no protruding ends . . . in 4 convenient sizes.

And at the RONDIC low cost, you can now afford to use these superior ball sponges for the following needs—in preference to any other dressing.

OPERATING ROOM

Prepping
Sponge-stick sponging
Tonsil sponges
Blunt dissection
Vaginal sponges
Rectal sponges

CENTRAL SUPPLY

Wiping hypodermic needles
For cleansing skin during dressing changes
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Protecting hypodermic needles

EMERGENCY

Alcohol sponges Medication sponges

Curity

RONDIC® SPONGES

BAUER & BLACK

Division of The Kendall Company

classified advertising

POSITIONS OPEN

NURSES—General duty and Relief; 40-bed acute and convalescent polio and crippled children's unit connected with 200-bed general hospital; 40-hour week; good personnel policy; starting salary $220 to $230 per month. Apply, Supervisor, Polio Cottage, Burge Hospital, Springfield, Missouri.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Registered, staff; for 7-3:30 and 3-11:30 in a pediatric hospital for surgical, medical floors and operating rooms; 40-hour week; liberal personnel policies. Apply, Director of Nursing, Babies' Hospital-Coit Memorial, 15 Roseville Avenue, Newark, New Jersey.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—The Institute of Living offers appointments to the staff of one of the most active psychiatric clinics in the country; practice and study in psychiatric nursing for graduate nurses; residence provided on campus within walking distance of downtown Hartford. Direct inquiries to: Director of Nursing, 200 Retreat Avenue, Hartford, Connecticut.

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—General staff; all services, general hospital in suburban Philadelphia; $2520-$2640 annually plus 1 meal and laundry; $20 differential per month for permanent evening and night duty; 40-hour week; 2-3 weeks vacation; 2 weeks sick leave; 7 holidays. Apply, Director of Nursing, Germantown Hospital, Philadelphia 44, Pennsylvania.

NURSES—General duty staff; urgently needed on all shifts; openings in all departments. Apply, Nursing Service Office, St. Mary's Hospital, Tucson, Arizona.

NURSES—Surgical and General duty; needed at a small progressive hospital; nice location, good working conditions. For full details, write to McLaughlin Osteopathic Hospital, 619 Townsend Street, Lansing, Michigan.

SALESMAN—Hospital; leading manufacturer of maintenance, sanitary and floor treatment chemicals requires experienced, strictly commission, institutional sales producer; five-figure per annum opportunity; permanent. Reply, MO 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SALESMEN—With hospital following, to sell surgical gloves; liberal commission; excellent opportunity for men with proven ability. Reply, MO 49, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR — And Clinical instructor for pediatrics; experience and advanced preparation necessary, preferably a degree; for modern 250-bed hospital, fully approved, 70 miles from New York City; 40-hour week; 3 weeks paid vacation; sick time; hospital care; complete maintenance, if desired, at $45 per month; beginning salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

(Continued on page 206)

classified advertising

POSITIONS OPEN

SUPERVISOR—Administrative, for operating room; a 400-bed general hospital, new modern 12-room suite; 40-hour week; salary open, depending on qualifications; mature, experienced person desired. Apply, Director of Nursing, Good Samaritan Hospital, Portland 10, Oregon.

SUPERVISOR—Of nurses; 85-bed communicable disease hospital in southeast Michigan resort area; beginning salary $3800 plus maintenance; comprehensive employee benefit program. Reply, furnishing resumé of training, experience and personal background: Oakland County Personnel Office, 1 Lafayette Street, Pontiac, Michigan.

SUPERVISOR—Obstetrical; for 150-bed approved general hospital in beautiful Midland Empire section of Montana near Yellowstone; active obstetrical service; collegiate school of nursing—full national accreditation; Bachelor's Degree and postgraduate course essential; good salary; 40-hour week, paid vacation, social security, hospitalization plan; position open now. Apply to Director of Nursing, Billings Deaconess Hospital, Billings, Montana.

SUPERVISOR—Obstetric; for 550-bed hospital expanding to 750 beds; in heart of medical center; salary open; 4 weeks paid vacation yearly; liberal personnel policy with provision for merit increases; 44-hour week; degree and experience required. Apply to Director of Nurses, Baptist Memorial Hospital, 899 Madison Avenue, Memphis 3, Tennessee.

SUPERVISOR—Operating room; 400-bed hospital averaging 550 operations a month; school of nursing accredited by National League for Nursing; administrative and teaching duties; salary dependent upon educational qualifications and experience; vacation four weeks, sick leave two weeks annually; retirement plan. Write, Director of Nursing, The Rochester General Hospital, Rochester 8, New York.

SUPERVISOR—Operating room; if you are interested in working in a 110-bed general hospital in a community of 30,000 population where you can save money, we offer an open salary, 3 weeks vacation, 6 sick days, 6 holidays, 44-hour week, coverage by social security and pleasant working conditions. Apply to Jack F. Hensley, Superintendent, Asbury Hospital, Salina, Kansas.

SUPERVISOR—Teaching; immediate opening in medical and surgical nursing; degree required; attractive, new 220-bed hospital; salary $4200-4800; four weeks vacation. Inquire: Director of Nursing, Bradford Hospital, Bradford, Pennsylvania.

TECHNICIAN—Laboratory; to complete staff of three in 100-bed hospital; good hours with full maintenance; salary open. Apply, Administrator, Stanly County Hospital, Albemarle, North Carolina.

TECHNICIAN—To manage laboratory of clinic composed of nine doctors, air-conditioned building. Reply, Box 2068, West Palm Beach, Florida.

THERAPISTS—Two staff openings for chief physical therapist and assistant therapist; experience in polio cases desirable; excellent opportunity in 200-bed hospital; good starting salaries; located between Denver and Yellowstone Park. Apply, Personnel Director, Memorial Hospital, Casper, Wyoming.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical; teaching hospital, 350 beds; plans completed for new medical center including hospital of 500 beds. (b) Assistant medical director; large teaching hospital; east. (c) Lay; voluntary general hospital, 340 beds; residential town located in resort area; east. (d) Voluntary general hospital, 300 beds; medical school affiliation; university city; Pacific coast. (e) General 225-bed hospital expansion program; large city, medical center; midwest. (f) Community hospital; blueprint stage; 115 beds; east. (g) Small general hospital; residence provided; resort town, Florida. (h) Assistant administrator; 400-bed general hospital; university city; midwest. MH9-1

(Continued on page 208)

Hexachlorophene in Dial Antiseptic Soaps assures faster scrub-ups, greater protection!

Even after you've gone through a conventional ten-minute scrub-up, *your hands could be cleaner, Doctor!*

Tests have shown that the surgeon who uses a soap containing Hexachlorophene removes in only *three* minutes *ten times more* skin bacteria than he does with a conventional *ten-minute* scrub-up, followed by a germicidal rinse.

Dial Liquid Antiseptic Soap was created by Armour to give you this greater safety factor—to provide you and your patients with more potent protection. Both the 20% and Concentrate Dial contain 5% Hexachlorophene, based on soap content—your assurance of truly effective germicidal protection. They are available in 5, 30 and 55-gallon steel drums.

Use DIAL Soap to protect nurses and patients

Hexachlorophene protection is available for nurses and patients in DIAL bar soap. With today's shorter hospital stays, many hospitals find it economical to provide the ¾-ounce guest size of DIAL for their patients' daily toilet. DIAL, even though it contains Hexachlorophene, *costs you no more* than ordinary soaps. It is available in ½ and 2½-ounce sizes, both *wrapped* and *unwrapped*, and ¾- and 1-ounce sizes, unwrapped only.

ARMOUR *Industrial Soap Department*

Armour and Company • 1355 West 31st Street • Chicago 9, Illinois

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ADMINISTRATORS-NURSES. (a) New general hospital, 60 beds; college town midsouth. (b) Convalescent hospital for crippled children; medical school affiliation; university city; south. (c) New 100-bed pediatric hospital; university center; midwest. (d) General hospital, 125-beds; operated by important industrial company; South America. MH9-2

ANESTHETISTS—(a) Modern general hospital, 100 beds; college town; midwest; $500, complete maintenance. (b) New hospital, foreign operations, large company; $8200. (c) Three; association, group of anesthesiologists; New England. (d) Association, 10-man group, Diplomates or eligible; college town; $600. MH9-3

COLLEGE CLINIC—(a) Director, student health; liberal arts college. (b) Clinic nurses; long established group; California. MH9-4

DIETITIANS—(a) To succeed chief dietitian, resigning after 24-year tenure; general hospital, 600 beds; east. (b) Chief; new hospital, 400 beds, affiliated medical school; west. (c) Chief; hospital operated by leading industrial company; Central America. (d) Assistant administrative, therapeutic and teaching dietitians; large general hospital; Canada. (e) Special diet; one of leading hospitals, southern California. MH9-5

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) General 400-bed hospital, chief unit, university group; medical center; east. (b) General 475-bed hospital; 170 students; all departments well staffed; interesting city outside continental United States; although tropical country, mild pleasant climate. (c) General hospital, 250 beds; university town, two hours from Chicago; excellent school. (d) to succeed director retiring after long tenure; one of leading hospitals, New York City. (e) Nursing service; new hospital, 325 beds; Pacific coast. (f) Nursing service; new hospital, 125 beds; college town; south. (g) Assistant director, school of pediatric nursing; children's hospital, affiliated medical school. MH9-6

EXECUTIVE HOUSEKEEPER—Beautiful new hospital, general; department staff of 26; Pacific coast. MH9-7

EXECUTIVE PERSONNEL—(a) Personnel director, 600-bed teaching center, expansion program; east; $8000. (b) Office manager; strong accounting background required; 350-bed general hospital; university city; midwest. (c) Purchasing director; 400-bed hospital; unit university group; medical center; east. (d) Comptroller; general 275-bed hospital; college town, New England. (e) Business manager; new hospital, 150 beds; suburban location; east. MH9-8

(Continued on page 210)

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Chairman, university nursing education department currently being instituted; qualified faculty in sciences, humanities, general education will contribute to program; up to $9000. (b) Educational director; new program for graduate nurses working toward advanced degrees; California. (c) Coordinator, three-hospital nursing education program; collegiate affiliations; 250 students; university city. (d) Instructors in Operating room, obstetrics, pediatrics, nursing arts; faculty appointments at university level; Pacific coast. (e) Associate or assistant professors in: public health, medicine, surgery, psychiatry, obstetrics, pediatrics, communicable diseases; state university. MH9-9

RECORD LIBRARIANS—(a) To succeed chief of department, 450 beds, retiring after tenure 27 years; university town, east. (b) Chief; large general hospital affiliated university medical school; university medical center, west. (c) Chief; new hospital; well endowed; coastal and resort town; southwest. (d) Fairly large general hospital; university city; Pacific northwest. MH9-10

STAFF AND SURGICAL NURSES—(a) Beautiful new hospital; near university campus, opportunity continuing studies; Pacific coast. (b) Staff; Pacific Islands; $4290, apartment (shared), transportation. MH9-11

Old one out...
New one in...
IN NO TIME!

Just like that! All the wearing parts of the Dial-ese faucet control are in the little cartridge you see in the engineer's hand. He takes the old one out and puts a new one in, in a minute or less!

Crane Dial-ese faucet controls not only stand up better—they're easier to replace

Crane Dial-ese faucets function perfectly, year after year. And when occasionally one does need attention, it only takes a minute to fix it . . . because all moving parts of a Dial-ese control are enclosed in a single cartridge that can easily be slipped out and replaced with a new one.

Because of these features, Crane plumbing can cut a hospital's maintenance costs . . . save your engineers time and trouble . . . and practically eliminate having fixtures "out of service."

And they save on water, too . . . because Dial-ese valves close *with* the flow of water, not against it, so the force of the water helps hold the valve closed to prevent leaks of costly hot water.

Check these important matters in your Crane hospital catalog, and talk them over with your Crane Branch, Crane Wholesaler or Plumbing Contractor. You'll see that Crane first costs are low, too!

Here are some of the reasons why Crane's Dial-ese faucet controls stand up longer and reduce maintenance costs:

A Permanently lubricated threads

B Packing below threads keeps out water, prevents corrosion

C Dial-ese cartridge contains all working parts, lasts longer

D Faucet closes with flow of water

CRANE CO.

GENERAL OFFICES: 836 SOUTH MICHIGAN AVE., CHICAGO 5

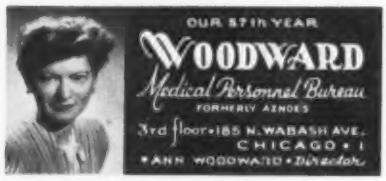
VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

SUPERVISORS—(a) Operating room; beautiful new pediatric hospital, well endowed; resort city, west. (b) Pediatric; 40-bed department; 300-bed hospital; collegiate program; Pacific coast. (c) Respiratory center; large teaching hospital; $4500. (d) Obstetrical; new small hospital, well equipped, excellent medical staff; college and suburban town, near Chicago. (e) Surgical; large teaching hospital; university center; midwest. (f) Psychiatric; new department, teaching hospital, south. (g) Orthopedic; new department, 300-bed hospital; college town, midwest. MH9-12



ADMINISTRATORS—(a) Medical; university hospital, 350 beds; unit of new medical center. (b) Lay; new university hospital; plans being completed for new medical center. (c) Important general hospital, large size; affiliated university medical school; California. (d) University hospital, 500 beds; large city; university medical center. (e) General nonprofit hospital, 180 beds; college town 50,000; one of most desirable localities on west coast; opportunity very pleasant living. (f) General hospital newly opened, 180 beds; large university city; northeast.

WOODWARD—*Continued*

ADMINISTRATORS—NURSES. (a) Farm for convalescent children; 50 beds; direct and coordinate various services; nursing, social work, elementary education; prefer M.S. in field related to services; $5000, maintenance. (b) Small hospital to open several months; near Cleveland.

ANESTHETISTS—(a) Head nurse anesthetist; fairly large hospital; outstanding surgical staff performing heavier types of surgery; to $7200; southeast. (b) Clinic-group 17 distinguished specialists; about $6000; large city; mideast.

CLINIC—COLLEGE NURSES. (b) two; excellent clinic-hospital; privately owned; California. (c) 6-man clinic; own hospital; college town 30,000, Ohio. (d) Health center of liberal arts college; opportunity study for B.S.; lovely college town 30,000; central.

DIETITIANS—(a) Chief; voluntary general hospital, 125 beds; kitchen received national awards from ADA; will meet salary requirements; central. (b) Chief; general voluntary hospital, 160 beds; building new wing; large city; university medical center; Pacific Northwest. (c) Chief; general hospital, 200 beds; new kitchen, cafeteria; 2-room apartment, minimum charge; large town near Boston.

WOODWARD—*Continued*

DIRECTORS OF NURSES—(a) 175-bed general hospital; medical school affiliation; faculty appointment; large city; university medical center; midwest. (b) Private hospital, 50 beds; to $6000; California. (c) General hospital, 150 beds; to $6000; residential town near Chicago.

FACULTY POSTS—(a) Educational director; general hospital, 600 beds; large city; university medical center; central. (d) Nursing arts instructor; accredited school; fairly large general hospital; large city; central. (e) Clinical instructor; medical and surgical; general hospital, 250 beds; town 100,000, near Chicago.

PUBLIC HEALTH—(b) To plan and direct public health education program; city 500,000; civil service; west.

SUPERVISORS—(a) Pediatrics; collegiate school; 110 students; 4-year program; affiliated with large hospital with outstanding pediatric department; Pacific Northwest. (b) Obstetrical; small new hospital; minimum $350; wealthy and exclusive suburb of Chicago. (c) Surgical; new surgical wing; general voluntary hospital, medium size; degree and postgraduate work desired but not necessary; southern California. (d) Operating room; general hospital, 450 beds; active surgical unit, averaging 500 majors and minors per month; department well staffed; college town 40,000; southeast.

(Continued on page 212)

classified advertising

POSITIONS OPEN

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ASSISTANT ADMINISTRATOR—East; 200-bed teaching hospital affiliated with well known university medical school; some experience in hospital administration in addition to formal training in one of the approved hospital administrative courses; excellent opportunity; will consider either a man or woman; $6000.

PERSONNEL DIRECTOR—East; 310-bed hospital; personnel totals about 550; department recently reorganized and offers a good opportunity for someone who has the ability to expand the department by setting up training programs, employee projects, etc.; salary will depend upon qualifications.

ADMINISTRATOR—East; new hospital needs a man who has had good experience in fund raising and some experience in the supervision of construction and planning; hospital is to be about 80 beds; this is an excellent opportunity to get in on the ground floor and build a very fine future.

DIETITIANS—(a) Assistant; salary to $5000; 550-bed hospital in large eastern city. (b) Chief; east; complete charge of dietary department; also supervise teaching program for student nurses; minimum $5000. (c) Therapeutic director; full charge of special diet department in 600-bed teaching hospital; to $6000. (d) Chief; middle west; 275-bed hospital in city of 50,000; 60 employees in department; $5400.

EXECUTIVE HOUSEKEEPERS—(a) East; 700-bed hospital; facilities complete and modern. (b) Middle west; 500-bed hospital in city of 300,000; must have good administrative experience. (c) Southeast; new 70-bed hospital located in very cosmopolitan community. (d) Middle west; 400-bed hospital; 3 assistant department heads. (e) California; 500-bed hospital; plan to reorganize department; require someone with outstanding organizational ability.

PHYSICAL THERAPISTS—(a) California; require someone qualified to handle duties in general hospital which will include: arthritic, orthopedic, polio and cerebral palsy cases; $400 to start. (b) East; head active department of 185-bed hospital; $4500. (c) Southwest; 100-bed hospital affiliated with university; $4200 minimum. (d) Middle west; 250-bed general hospital in city of 100,000; $400 minimum to start. (e) Chief; hospital is part of large children's medical center and is fully approved; $400 minimum.

PHARMACISTS—(a) Middle west; 160-bed hospital; active department; serve hospital patients only; $400 plus maintenance. (b) Chief; east; new department; will have 4 or 5 employees; 300-bed hospital in community of about 20,000; salary to $5000. (c) West; 82-bed hospital, fully approved; to $5000. (d) California; 200-bed general hospital; complete charge of department; $5000. (e) Middle west; 350-bed hospital; 5 in department; located in city of 100,000; $5000.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 125-bed hospital, new; to be opened January, 1954; near university center, midwest. (b) 85-bed hospital, central states; under construction. (c) 65-bed hospital, Ohio. (d) 125-bed hospital, southeast.

ASSISTANT ADMINISTRATORS—(a) 250-bed Michigan hospital. (b) 250-bed hospital; New England.

NURSE ADMINISTRATORS—(a) 40-bed hospital, Indiana. (b) 40-bed hospital, Michigan. (c) 60-bed hospital, Delaware. (d) Florida. (e) 55-bed hospital, Iowa.

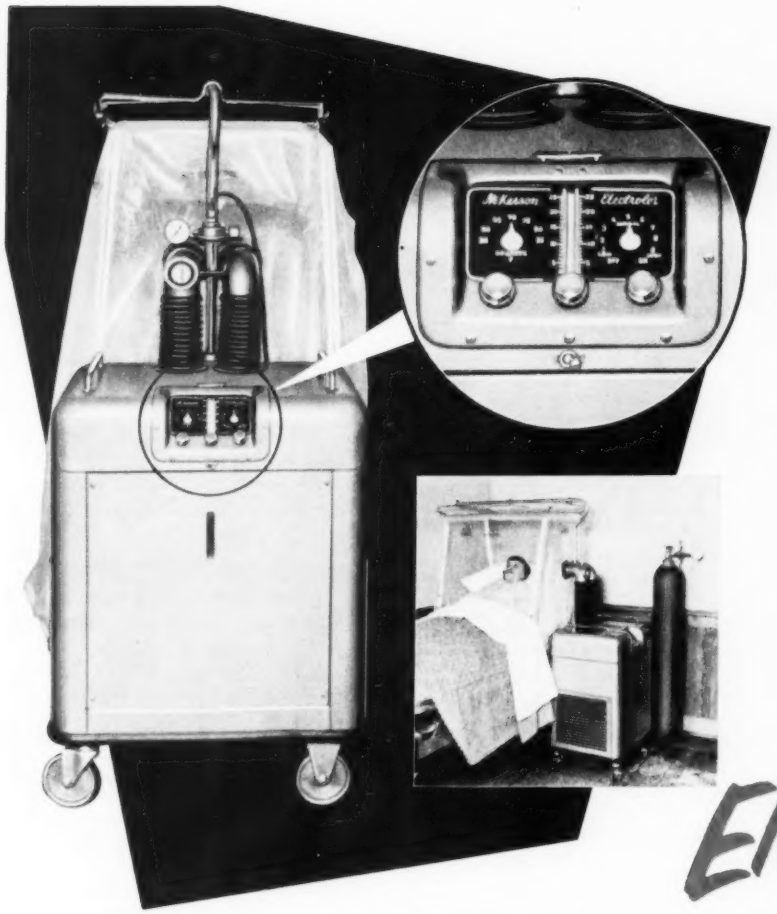
COMPTROLLER—300-bed hospital, New England.

ADMINISTRATIVE DIETITIANS—(a) New England; $5000, maintenance. (b) 200-bed Ohio hospital; $5200. (c) Therapeutic; to $375.

DIRECTORS, NURSING SERVICE—(a) 300-bed hospital, east. (b) New 250-bed hospital, midwest. (c) 350-bed hospital; western university city. (d) 150-bed hospital, Ohio.

EDUCATIONAL DIRECTORS—To $6000.

(Continued on page 214)



Why nurses, patients and hospital executives prefer Electrolors

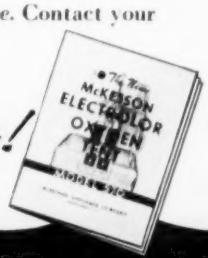
NURSES—See that modern inlaid Panel in circle above? It's lighted from inside—with Green to indicate Oxygen, and Red for Temperature and Blower Control. *The nurse can read it in dark.* She doesn't have to turn on any lights at night.

PATIENTS—Think what that means to patients, too—no interrupted sleep while nurse turns on lights to read Panel Indicators—no sapping of precious strength, but maximum refreshing sleep.

HOSPITAL EXECUTIVES—Electrolor's low initial cost, extremely low maintenance (if any), long-lasting qualities and handsome modern appearance—these are the features which appeal most to those who make the final decisions.

Compare features! Compare prices! See a demonstration *at your convenience.* Contact your McKesson Dealer or—

Write Today for McKesson Electrolor Brochure!



McKesson ELECTROLOR Oxygen Tents

McKESSON APPLIANCE CO., TOLEDO, OHIO

Manufacturers of these major products—Bronchio Spirometry, Anesthesia, Resuscitators, Suction Pumps, Metabolism, Oxygen Tents, Analgesia, Vital Capacity, Pneumothorax, Air Compressors, Rocking Beds, Dermal Temperature, Oxygen Therapy

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) 200-bed new hospital, south. (b) 300-bed hospital, modern; New England. (c) 150-bed New Jersey hospital. (d) 300-bed hospital, California. (e) 175-bed Ohio hospital.

PERSONNEL DIRECTORS—(a) 300-bed Ohio hospital. (b) 325-bed Sisters' hospital, midwest.

PHARMACISTS—(a) Chief; suburb of New York; $5500. (b) 250-bed Michigan hospital. (c) Oregon.

PURCHASING AGENTS—(a) 450-bed hospital, east. (b) 250-bed Ohio hospital; 2 years experience.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

SURGERY NURSE—Also assist in deliveries, which are few; 50-bed approved hospital, copper mining area; excellent working conditions; $390 plus maintenance.

GENERAL DUTY—Fairly recent graduate for 50-bed hospital, small western town, elevation 6000 feet; $350 plus maintenance.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

ANESTHETIST—October 1; 200-bed hospital; employ several; 5-day week; no night calls.

DIETITIANS—(a) Therapeutic, ADA; 355-bed hospital, New England; start $4100; 40-hour week. (b) Head; 94-bed hospital; salary open, will be good.

DIRECTORS OF NURSES—(a) 100-bed hospital, Maryland. (b) New 35-bed hospital, Pennsylvania. Graduate staffs; salaries open.

EXECUTIVE HOUSEKEEPER—200-bed hospital, east; 5-day week; salary open.

LAUNDRY MANAGER—300-bed hospital, New Jersey; salary open.

MEDICAL RECORD LIBRARIAN—Head; 247-bed hospital; start $3900 plus maintenance.

TECHNICAL LIBRARIAN—For research and development department; large drug company; $5000.

PHYSICIANS—January 1, 1954. (a) Pathologist. (b) Radiologist. Certified or eligible, to head departments; 240-bed approved general hospital; good financial arrangements.

COLLEGE PHYSICIAN—Male; assistant health director, large school; start $8000 plus meals.

ASSOCIATE PSYCHIATRIST—Small private hospital; minimum starting $10,000.

No charge for registration

(Continued on page 216)

PLACEMENT BUREAUS

HOSPITAL PERSONNEL BUREAU
Charles J. Cotter, Director
(Licensed Employment Agent)
Professional Arts Bldg.
Hagerstown, Maryland
Telephones: Office—950; Res.—2885

Positions available, most areas. Administrators, Pathologists, Anesthetists, Pharmacists, Housekeepers, Technicians, Dietitians, Librarians, Director of Nurses and all nursing positions. Send resumé, 10 snapshots, date available.

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

Year after year

THURMADUKE

has been the Model to imitate

According to the dictionary, an *imitation is a counterfeit of something superior.*

Some years ago we introduced the original THURMADUKE Waterless Food Warmer, an entirely new conception of food warming that eliminated the unsanitary and wasteful water-pan, slashed operating costs and reduced shrinkage and flavor loss.

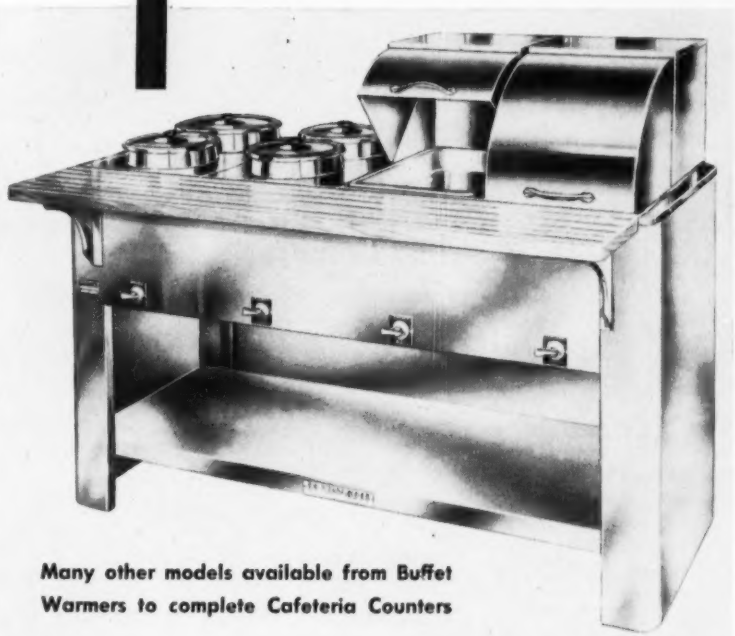
Within a short time, the imitators entered the field with food warmers that "looked like THURMADUKE" but did not *work* like THURMADUKE.

Since then, each improvement and each new idea that has come off THURMADUKE production lines has been something new for them to imitate.

Before you buy any food warmer, be sure to investigate the original waterless THURMADUKE.

Call your nearest THURMADUKE Dealer or write us for Illustrated Catalog MH-539

1. Saves up to 70% in heating costs.
2. Reduces shrinkage—gives extra servings.
3. Preserves flavors. Reduces waste.
4. Cooler—no steam. Reduces load on air conditioner.
5. Less cleaning time. Saves man hours.
6. Ruggedly built for longer life.



Many other models available from Buffet Warmers to complete Cafeteria Counters

DUKE MANUFACTURING CO. • ST. LOUIS 6, MO.

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PLACEMENT BUREAUS

THE MEDICAL FIELD
EMPLOYMENT AGENCY
790 Broad Street — cor. Market
Newark 2, N.J.
MItchell 2-1940, 1941

A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

CALIFORNIA AND WEST COAST
Complete Coverage
Hospitals—Clinics
Excellent Openings—Confidential Services

CONTINENTAL MEDICAL BUREAU, Agency
510 West 6th Street, Los Angeles 14

PACIFIC COAST MEDICAL BUREAU,
Agency
703 Market Street, San Francisco 3

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N. Y.
Mary A. Johnson, Ph.D., Director
FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

(Continued on page 218)

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director
Suite 1004—79 West Monroe Street
Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

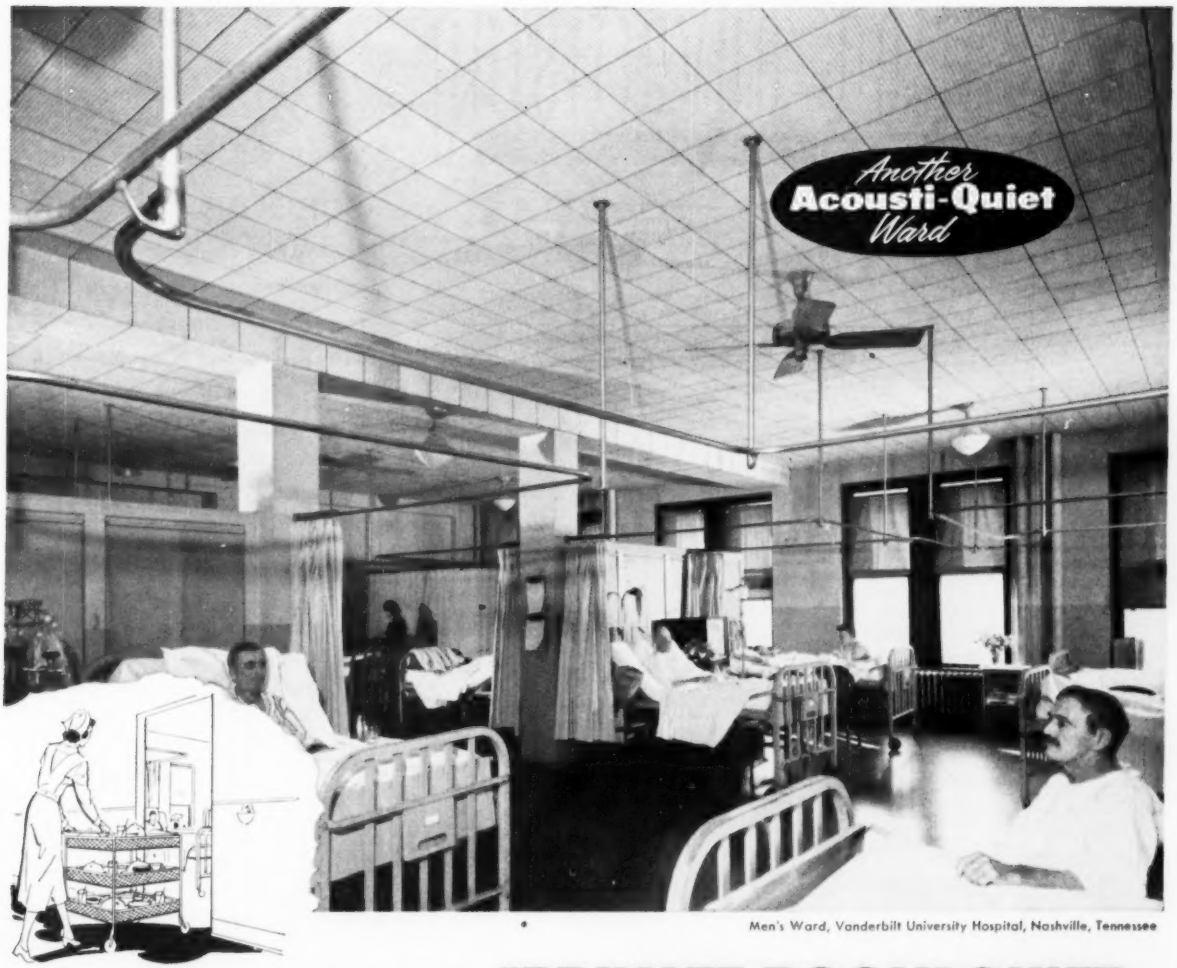
BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director.
We Do Not Charge a Registration Fee.

FOR SALE

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.



Men's Ward, Vanderbilt University Hospital, Nashville, Tennessee

Now, even wards have "PRIVATE ROOM" QUIET

With people walking and talking, equipment being moved, trays and dishes clattering—wards can be a noisy headache. But as hundreds of hospitals have discovered, routine noise need not be allowed to rob ward patients of the relaxing quiet they need for convalescence. It can be controlled . . . effectively and economically!

Low-Cost Solution

Acousti-Celotex Sound Conditioning is the answer. A sound-absorbing ceiling of Acousti-Celotex Tile checks noise in wards, operating and delivery rooms, nurseries, private rooms, corridors, lobbies, kitchens, utility rooms. It brings *soothing quiet* that helps patients rest and relax, and enables hospital personnel to work more efficiently.

DOUBLE-DENSITY—As the diagram shows, Acousti-Celotex Tile has two densities. *High density* face, for a more attractive finish of superior washability, easy paintability. *Low density* through remainder of tile, for greater sound-absorption value.

Easy Maintenance

Acousti-Celotex Tile is quickly installed at moderate cost. Requires no special maintenance. Its remarkable *double-density* feature (see diagram) prevents warping—gives a surface of unrivaled beauty and washability. Can be washed *repeatedly* and painted *repeatedly* without impairing its sound-absorbing properties!

GET A FREE ANALYSIS of the noise problem in your hospital without obligation. We will also send you free a factual booklet, "The Quiet Hospital." Mail coupon!

ACOUSTI-CELOTEX

TRADE MARK REGISTERED U. S. PAT. OFF.

Sound Conditioning

Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. La Salle St. Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec

Mail coupon today

The Celotex Corporation, Dept. G-93
120 S. La Salle St., Chicago 3, Ill.

Without obligation, I would like . . .

- ☐ A free analysis of the noise problem in my hospital.
- ☐ A free copy of your booklet, "The Quiet Hospital."

Name_____

Address_____

City_____ Zone____ State_____

classified advertising

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

400 East 59th Street, New York City

EXCLUSIVE NURSING HOME

In North Shore suburb of Chicago. Three buildings on ground, including cottage with 3 rooms, bath and garage, and new ranch home for owner. Prosperous business, grossing $202,000 in the past three years; 33-bed capacity; 4½ acres beautifully landscaped, with enclosing cyclone fence; plenty of room for extension. Selling because of serious illness of owner. Require $58,000 down payment; owner will carry balance on contract. Reply, MS 54, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

FOR SALE

ELECTRIC FOOD CONVEYORS

3 IDEAL
Five wells—Ment Compartment
Model 2231 X
35-Patient Capacity

3 PROMETHEUS
Seven wells—Two Meat Compartment
35—50 Patient Capacity
Type 1038
$75.00 each FOB Dayton

Write
Jack K. Marshall, Business Manager
Stillwater Sanatorium
8100 N. Main St.
Dayton 5, Ohio

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

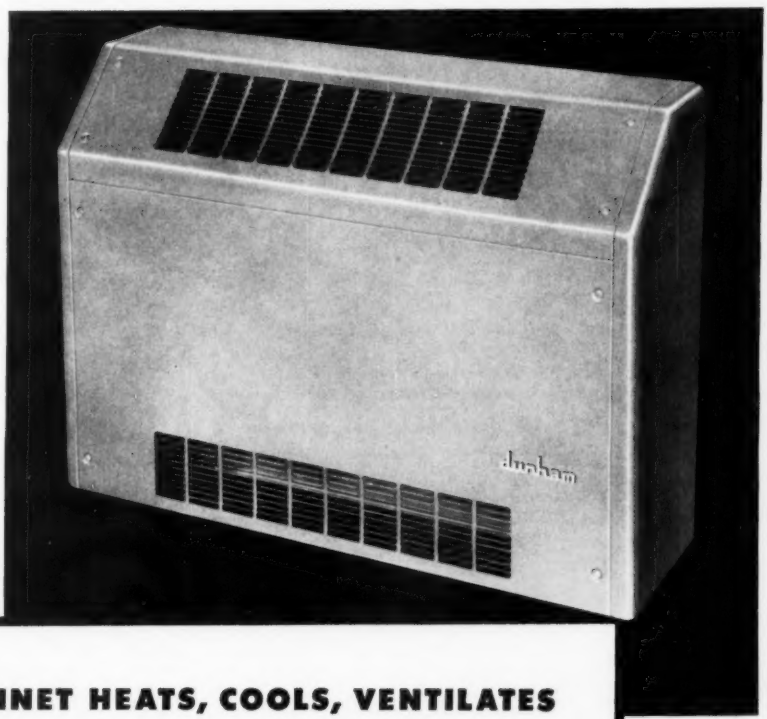
"Set for silent operation"

"Easy to mount on floor, wall or ceiling"

"Uses hot and cold running water"

introducing

VARI-TEMP



NEW DUNHAM CABINET HEATS, COOLS, VENTILATES TO SUIT INDIVIDUAL ROOM REQUIREMENTS

New Dunham "Vari-Temp" Cabinets now put year 'round air conditioned comfort within reach of every budget . . . and within easy reach of every room occupant. For "Vari-Temp," with twin blower fans, heats, cools, ventilates, filters and dehumidifies *on an individual room basis.*

Since there's no need for central system duct work, Dunham "Vari-Temp" costs less to install and maintain. A single riser, connected to the unit, supplies hot water for heating—chilled water for cooling. Units are also available for heating with steam coil, or heating and ventilating with non-freeze steam coil.

In addition, these handsome, compact cabinets save space. *One "Vari-Temp"* delivers the same amount of heat as *five radiators* equal to it in size!

For further information about space-saving, money-saving, room-controlled Dunham "Vari-Temp" Cabinets . . . clip and mail the coupon.

DUNHAM **VARI-TEMP CABINETS**

RADIATION • UNIT HEATERS • PUMPS • SPECIALTIES

C. A. DUNHAM COMPANY • CHICAGO • TORONTO • LONDON

C. A. DUNHAM COMPANY
Dept. MH-9, 400 W. Madison Street
Chicago 6, Illinois

Please send your "Vari-Temp" Literature.

Name_____

Company_____

Address_____

City_____ Zone____ State_____

"Fresh up" with Seven-Up!

The All-Family Drink... so pure,
so good, so wholesome for everyone!

You like it... it likes you!

GET A FAMILY SUPPLY OF 24 BOTTLES.
Buy 7-Up by the case. Or get the handy 7-Up Family Pack. Easy-lift center handle, easy to store.

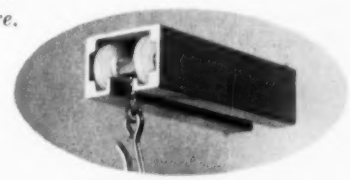
A NEW ARNCO CEILING TYPE CURTAIN CUBICLE

EXCLUSIVE ARNCO ALUMINUM TRACK
MAY BE FLUSH OR SURFACE MOUNTED
WITH EITHER PLASTER OR ACOUSTIC CEILING

Here at last is a practical system of bed screening that is completely unobtrusive, does not conflict with lighting or wall fixtures, and which eliminates any possibility of interference with doors or windows. Specially designed curtains provide adequate ventilation along with privacy.

ARNCO ceiling track and carrier units are specifically designed for durable performance under the rugged and continuous service required of hospital cubicle equipment. The carrier features plastic wheels on a zinc die cast axle, a bead chain for flexibility and a rust-proof curtain hook.

The smooth performance, neat appearance and great durability of ARNCO ceiling type cubicles merit your interest.
Write for literature.



ARNCO Cubicles are also available in the suspended type.

A. R. NELSON CO., INC.
210 East 40th Street · New York 16, N. Y.

"... More than 50% of our employees are on the Payroll Savings Plan..."

PAUL W. JOHNSTON
President, Erie Railroad

"We on the Erie Railroad are extremely proud that 50% of our employees are on the Payroll Savings Plan for U.S. Defense Bonds. These thousands of employees are regularly providing for their own future security and at the same time contributing to the strength of our national defense. The American habit of thrift and regular purchase of U.S. Defense Bonds Shares in America are evidences of good, sound citizenship."

Good, sound citizenship . . . the American habit of thrift . . . a belief that a strong America is a secure America . . . a management that makes the Payroll Savings Plan available to *all* its employees—these are the reasons why more than 50% of Erie Railroad employees are enrolled in the Payroll Savings Plan.

For the same four reasons, more than 7,500,000 employed men and women in thousands of other companies are active members of the Payroll Savings Plan—their take-home savings in the form of U.S. Defense Bonds total more than $150,000,000 per month.

Is your company in the "more than 50% participation" group? If it isn't, please bring this page to the attention of your top executive. Point out to him—

Two Simple Steps to a Successful Payroll Savings Plan

1. Phone, wire or write to Savings Bond Division, U.S. Treasury Department, Suite 700, Washington Building, Washington, D. C.
2. Your State Director, Savings Bond Division, will show your company how to conduct a simple person-to-person canvass that will put a Payroll Savings Application Blank in the hands of *every* employee.

That is all management has to do. Your employees will do the rest. They, like the employees of the Erie Railroad, want to provide for their personal security and at the same time do their part in helping to keep America strong.

The United States Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

ABC *is simple....*

● **OCTOBER IS ABC MONTH.** ABC stands for Audit Bureau of Circulations. The purpose of this "month" is to acquaint periodical readers throughout the country with the significance of ABC to those who buy magazine subscriptions. ABC was established in 1914 by periodical publishers and those who buy advertising space in periodicals. Its purpose is to provide a standard measurement of periodical audiences on the basis of paid subscriptions, so that the buyer of advertising space may know exactly how much—and what—his advertising dollars are purchasing. (Incidentally, The MODERN HOSPITAL's charter membership is recorded as May 9, 1914—eleven days prior to the formal organization of the Bureau.)

• ABC is significant also to the reader of an ABC magazine. The ABC issues a statement at six-month intervals, which is provided by the publisher, and once a year audits the circulation records and issues an auditor's statement. This statement shows how many paid subscribers the magazine has. It shows how many subscribers pay for the magazine, and it shows how they were induced to pay—and how much.

• The statement for The MODERN HOSPITAL shows that every subscriber paid the full published price of $3.00 per year. It shows that The MODERN HOSPITAL used no inducements such as premiums, cut rates, short-term offers or any other inducement beyond the actual service which the magazine renders to its readers.

• The subscriber to The MODERN HOSPITAL is, therefore, a member of a group which has consciously decided that it wants the kind of service which The MODERN HOSPITAL renders. If it were not for the analytical paragraphs in the ABC, this fact would not be clear. We, the publishers of The MODERN HOSPITAL, believe that such facts have genuine significance to the reader. Every six months we are able to measure exactly in terms of dollars paid for subscriptions how well you, the readers, like the kind of service we give you.

• In these times, when hospital costs are rising, when there is agitation in certain political quarters toward federal impingement upon America's hospital system, when there are controversies within the hospital field, clashes between hospitals and other groups in medicine and in society, we believe that you as readers of the magazine need a forum from which your voice may be heard—a continuing analysis of national and world events which bear upon your problems—an independence of thought and criticism, unhampered by any group pressures, whose rightness in the long run you yourselves will judge.

• This is the kind of service The MODERN HOSPITAL seeks to render, and its success or failure depends directly upon the temper of you, our readers. That temper is expressed very largely in your wish to read the magazine and your willingness to pay the full published price and to keep on subscribing year after year. (In our case, the current statement shows that 82.99% of our readers renewed their expired subscriptions voluntarily.) These are the things which ABC measures for us. That is ABC's significance to you.

The Modern Hospital Publishing Co., Inc.

919 NORTH MICHIGAN AVENUE, CHICAGO 11, ILLINOIS

4 better ways... to beat large-scale traffic problems

SHINES IN MINUTES — LASTS FOR WEEKS. STANDARD Liquid Wax holds its gloss and resists scratching under heaviest traffic. No buffing, easily applied with mop or pad. Recommended for linoleum, rubber tile, composition, and finished hardwood floors. Water emulsion base, not petroleum. Meets Underwriters Laboratories anti-slip requirements.

NON-SLIP—PERMANENT SEAL. STANDARD Penetrating Sealer (Heavy Duty) penetrates pores of wood, seals with hard waterproof gums and oils. Forms non-slip, non-gloss surface. Excellent base for wax. Approved by Maple Flooring Mfrs. Ass'n. Meets Underwriters Laboratories anti-slip requirements.

NON-SLIP — HIGH GLOSS. STANDARD Super Finish (Gym Finish) gives high-gloss finish to gym and other wood floors. Tough, durable — resists rubber markings, boiling water, alkalies, mild acids, heat and cold. Also for cork, linoleum, magnesite, cement. Approved by Maple Flooring Mfrs. Association. Meets Underwriters Laboratories anti-slip requirements.

TOPS FOR FURNITURE, WOODWORK. STANDARD Liquid Gloss (formerly SEMDAC Liquid Gloss) restores lustre, helps conceal scratches. Cleans and polishes in one operation. Also preserves unfinished floors, holds down germ-laden dust. Fire-safe—Meets Underwriters Laboratories requirements.

FOUR BETTER WAYS. All four of these better ways to beat large-scale traffic problems are packaged in quantities up to full barrels and are available for immediate delivery from over 3900 warehouses in the Midwest. That means there's a convenient source of supply near you. Order now. If you have a special floor maintenance (or insect control) problem you can get expert advice from your nearest sales office, listed left, below. Call today for service.

STANDARD OIL COMPANY *(Indiana)*

Chicago, Ill. • Decatur, Ill. • Peoria, Ill. • Joliet, Ill. • Evansville, Ind. • Indianapolis, Ind. • South Bend, Ind. • Detroit, Mich. • Grand Rapids, Mich. • Saginaw, Mich. • Duluth, Minn. • Mankato, Minn. • Minneapolis, Minn. • Green Bay, Wis. • LaCrosse, Wis. • Milwaukee, Wis. • Des Moines, Ia. • Mason City, Ia. • St. Louis, Mo. • St. Joseph, Mo. • Kansas City, Mo. • Wichita, Kan. • Omaha, Neb. • Denver, Colo. • Cheyenne, Wyo. • Billings, Mont. • Huron, S. Dak. • Fargo, N. Dak.

STANDARD

What's New for Hospitals

SEPTEMBER 1953 Edited by BESSIE COVERT

To HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers Service Form on page 256. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Hollister "FootPrinter"

Perfect footprints of newborn infants are now possible, without mess or stain, with the new Hollister "FootPrinter." The new "dry plate" process, which is a feature of the model, makes it easy and simple to take a legally positive footprint without ink stain or clean up. The unit can be used equally effectively for adult fingerprinting.

The Hollister "FootPrinter" works on any kind of paper without special equipment or supplies. It is designed to fit the nurse's hand and comes in an attractive, tough nylon plasitc case. The low-cost replaceable impression plate takes from one to two hundred clean, readable, smudge-proof prints. Plates are easily changed when needed. **Franklin C. Hollister Co., Dept. MH, 833 N. Orleans St., Chicago 10. (Key No. 133)**

Utility Tray

The Continental Utility Tray has been redesigned for extra convenience and time and labor saving in medication service. The all-welded stainless steel tray is light in weight and easy to carry. It can be accommodated on standard hospital carts and one tray can be set up while another is being used for administering medications. Each tray has a large sanitary working area in front of the elevated racks that hold 20 medicine glasses. Patient identification and dosage cards fit into recessed slots in front of each glass.

A syringe drawer is available as a component part of the tray or it can be purchased separately. The drawer holds 15 syringes firmly and safely with patient card slot directly in front of each syringe. The cart to hold the tray and drawer is engineered for dependable, trouble-free service. **Continental Hospital Service, Inc., Dept. MH, 18624 Detroit Ave., Cleveland 7, Ohio. (Key No. 134)**

Mop Wringer

A new type of side and gear cover has been developed for the Model 1624 mop wringer. This improvement gives the entire line of Geerpres mop wringers completely enclosed gears, preventing tearing of mop strings and clothing and adding to the life of mops. Pressure bars on the Geerpres mop wringers are now spun at both ends into the double-staggered gears that produce the downward squeezing action of the mop. With these improvements, no moving parts contact

the mop at any time except the pressure plates that squeeze the water out and down into the bucket or tank. **Geerpres Wringer, Inc., Dept. MH, Muskegon, Mich. (Key No. 135)**

All-Purpose Bookkeeping Machine

Economical mechanization is offered in the new Remington Rand Low-Cost Bookkeeping Machine recently introduced. It is designed for small or large administrative operations and facilitates the preparation of Accounts Payable and Budgetary Control, as well as patient accounts and payroll requirements.

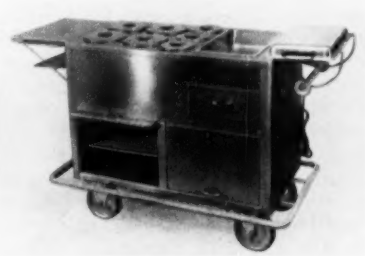
This complete bookkeeping machine produces multiple records with mechanical proof for every entry, instantly-computed account balances and automatically accumulated accounting control figures. Registers lock automatically if balances or totals are entered incorrectly. The 46 key, touch-operated, alphabetical-numerical keyboard combined with high-speed figure mechanism permits every item to be described as fully as desired. The machine features simplicity of construction and its operation can be learned by any competent typist in a minimum of time. The mechanical devices which govern the action of the machine guarantee accuracy. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 136)**

Greenline Food Conveyor

New features have been incorporated into the Greenline Food Conveyor to make this electrically heated unit easier to clean. The top and walls are of one piece stainless steel construction and all welds are polished and corners rounded to eliminate crevices.

The conveyor is generously insulated to reduce the consumption of electricity to a minimum. The heat of each well may be individually controlled for the various foods being served. As many as 100 patients may be served properly heated meals from the Greenline Food Conveyor.

Serving space is provided by shelves that fold down against the end when not needed. The bottom compartment has two lift-up disappearing doors mounted on stainless steel levers. The conveyor is mounted on ball bearing rubber tired wheels which, together with



the careful construction of the unit, permits quiet operation. **Robert M. Green & Sons, Inc., Dept. MH, Nesquehoning, Pa. (Key No. 137)**

(Continued on page 232)

What's New . . .

Bedside Television

Television can be provided to patients at a nominal charge without any cost to the hospital. At the same time, the hospital derives an income from the sets in use. An unlimited number of sets can be used in a hospital with the Transvision plan. The units have a master antenna service, specially engineered television chassis with 17 inch picture tube, quiet sound, local service and bedside control, in addition to the benefit to the patient of diversion while convalescing.

The television set has been especially designed for hospital rooms. It has a remote control unit which is connected by a flexible cable and can be placed beside the patient so that he has full control of the set. When not in use the control unit fits into a chamber in the front of the television cabinet. The patient can switch the sound from the set to a special outlet for sound on the control unit next to him, or he can use both speakers at once, each at different volume levels, permitting patient and visitors to enjoy television without disturbing others. Provision is made, with a hidden control, for hospital personnel to adjust and pre-set a master volume control for maximum sound. Volume is many times less than in standard sets.

The coin operated sets can also be used in waiting rooms, solariums and lounges as they are mounted on noiseless, easy rolling, heavy duty casters and have a tamperproof locked back. **Transvision, Inc., Dept. MH, New Rochelle, N.Y. (Key No. 138)**

Biological Inserts

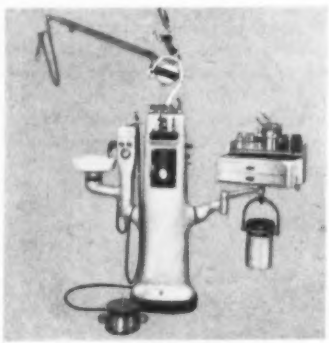
A new series of shelf accessories to equip standard refrigerators for biological use has been announced by Hotpoint Company. Called "biologicool" inserts, the drawers are constructed of chrome plated steel. They will fit interiors of all 1953 refrigerator models as well as some of the older models. The sides and bottoms of the drawers are perforated to allow maximum air circulation and each drawer has a catch to prevent pulling out, which can be removed if desired. Inserts have rubber bumper feet to hold the unit in place and to prevent marring the finish of the refrigerator liner. **Hotpoint Co., Dept. MH, 229 S. Seely Ave., Chicago 12. (Key No. 139)**

White Onex-Seal

Designed for sealing and finishing white Portland Cement, white marble and white terrazzo floors, the new White Onex-Seal recently introduced has a special formula developed by the manufacturer in his research laboratories. It has all the advantages of the original Onex-Seal for the protection of hard surfaced floors with a new ingredient to increase the whiteness of the surfaces. The product penetrates and seals the surfaces without yellowing or discoloring them and gives a hard, permeating finish which becomes an integral part of the floor surface to prevent surface checking and efflorescence and to protect against penetration of moisture and stains. **Hillyard Chemical Co., Dept. MH, St. Joseph, Mo. (Key No. 140)**

ENT-Oral Surgery Unit

For small hospitals and clinics requiring only the part-time services of an Ear, Nose and Throat Specialist or an



Oral Surgeon, the new Ritter ENT-Oral Surgery Unit provides one modern, complete outfit at moderate cost. It is a standard Ritter Ear, Nose and Throat Unit with the Ritter Engine added. Thus the combination unit provides all the essentials for ear, nose and throat work and oral surgery, and occupies less space than conventional equipment. **Ritter Company, Inc., Dept. MH, 404 West Ave., Rochester 3, N.Y. (Key No. 141)**

Diagnostic X-Ray Tubes

A pair of new diagnostic x-ray tubes has been introduced by General Electric. The lighter weight tubes have a minimum of parts, yet have blowers providing high heat dissipation. Known as the LRT and HRT, the tubes are designed for low-voltage and high-voltage radiography, respectively, and are adaptable to any diagnostic x-ray unit of any type, model or manufacture. The tube housing has non-porous, light weight, oil-tight construction, providing high shock resistance. Their small size gives greater table clearance, whether used underneath the table for fluoroscopy or interchangeably for both radiography and fluoroscopy. The tubes feature fast starting, increased electrical efficiency and long life. **General Electric Co., X-Ray Dept., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 142)**

Surgical Soap

Formulated for maximum antiseptic and germicidal value, Softasilk with Actamer is a new non-irritating surgical soap. Use of the soap for surgical scrub-up is said to reduce the time required to three minutes and to make it unnecessary to use germicidal rinses. The soap has low toxicity and is economical in price.

Softasilk is a formulation of highly refined and distilled vegetable oils and a unique buffer ingredient preserves the neutral low pH of the soap. The addition of 2 per cent of Actamer by total weight reduces resident flora of the skin by 97.4 per cent, according to the manufacturer. Softasilk with Actamer is suitable for use in all departments of the hospital for hand washing. **The Gerson-Stewart Corp., Dept. MH, Lisbon Rd., Cleveland 4, Ohio. (Key No. 143)**

High Temperature Tape

Autoclave bundles can be quickly and easily sealed with the new No. 216 Scotch Brand Pressure-Sensitive Tape. The tape also serves as a label since it may be written on with regular or ball-point pen, crayon or pencil without the marking blurring into the tape. The adhesive requires no moistening and sticks at a touch to linens, metals, paper, glass, plastic, wood and other clean, dry surfaces. It holds firmly, even on bulky, odd-shaped packs, holds the bundle safely closed, stays on through repeated autoclaving without drying out, curling, stretching or coming loose, and is easily and cleanly removed when pack is to be opened.

The tape can also be used to seal and label small tubes and vials, to make "finger tip" labels and to mark or seal

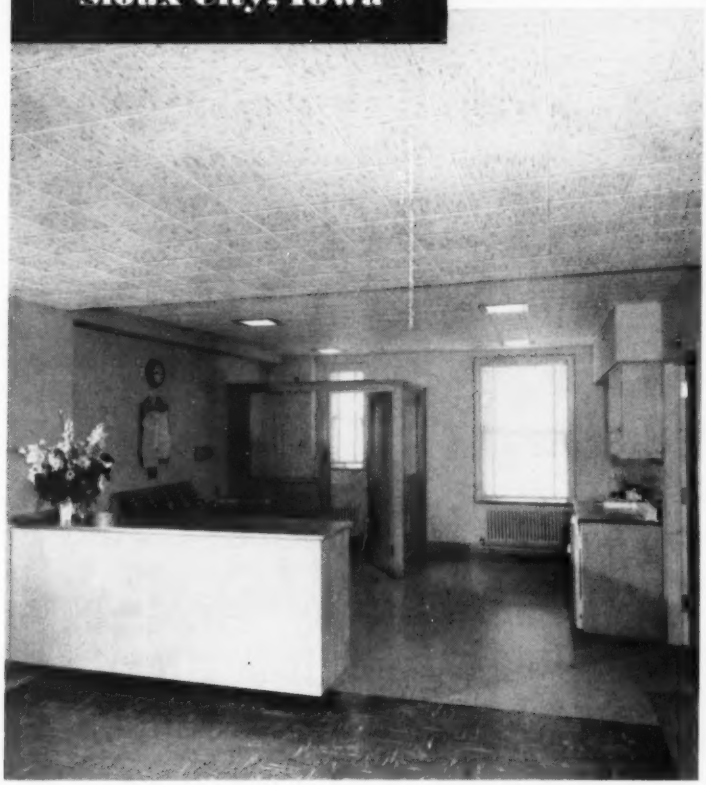
any container or bundle. **Minnesota Mining and Mfg. Co., Dept. MH, 900 Farquier Ave., St. Paul 6, Minn. (Key No. 144)**

(Continued on page 236)

LUTHERAN HOSPITAL, Sioux City, Iowa

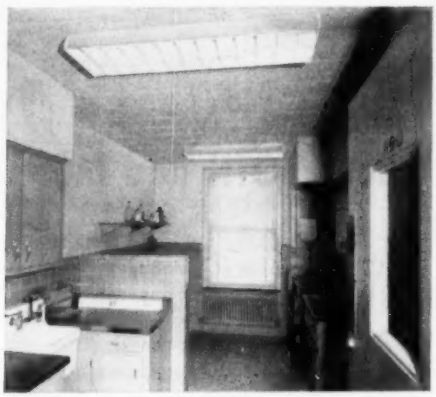
Architect: John Latenser & Sons

Acoustical Contractor: Simpson Insulation Co.



Busy nurses' stations keep comfortably quiet under sound-absorbing ceilings of Armstrong's Travertone.

On curved surfaces, 6" x 12" Travertone tiles were readily fitted to the ceiling contour. On the flat ceiling areas, 12" x 12" Travertone tiles were used.



Everything in this sterilizing room is easy to keep clean —including the noise-absorbing ceiling of Travertone.

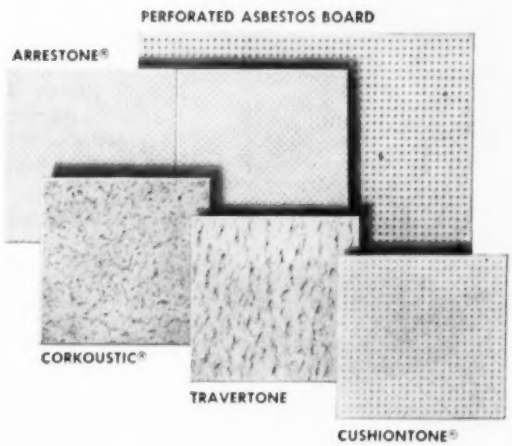
This ceiling adds beneficial quiet . . . extra fire-safety, too.

Noise-deadening ceilings of Armstrong's Travertone do two valuable jobs in Sioux City's Lutheran Hospital. Not only do they provide patients with the quiet needed for quick recovery, but they also contribute an important measure of fire-safety to the building. Made of mineral wool fibers, Travertone is completely incombustible.

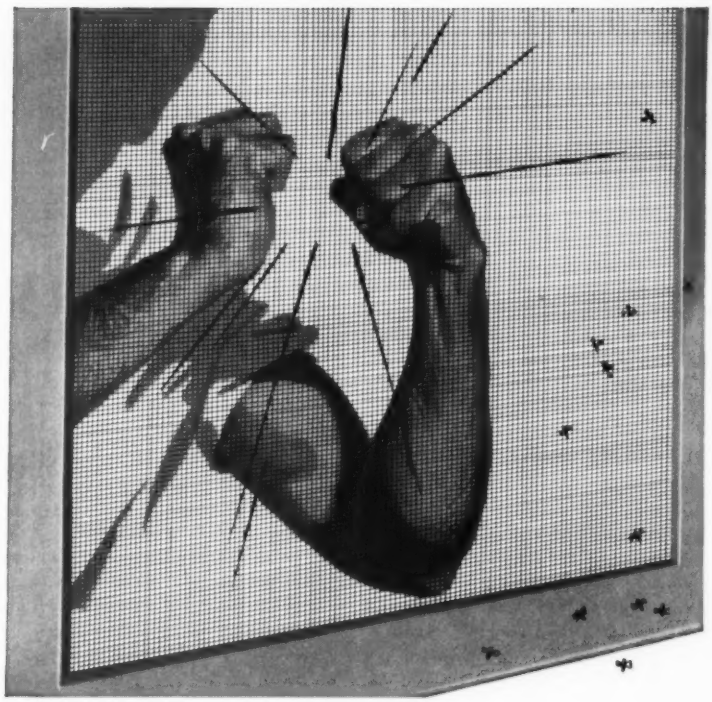
Travertone is an exceptionally efficient sound-absorber. Its attractively fissured surface and white paint finish lend distinctive beauty to the hospital rooms and corridors.

The Travertone was installed by cementing. It saved the expense of finish plastering and painting. Maintenance is easy and economical.

Call in your Armstrong Acoustical Contractor for full details on Travertone and Armstrong's other acoustical ceilings. There's one to meet every requirement. For the free booklet, "How to Select an Acoustical Material," write Armstrong Cork Company, 4209 Union Street, Lancaster, Pennsylvania.



ARMSTRONG'S ACOUSTICAL MATERIALS



Chamberlin Security Screens provide maximum detention; eliminate *all* insect screen costs

You save all insect screen costs. Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands years of violent abuse. Admits ample light and air.

You cut sash repairs and painting costs. Chamberlin Security Screens, mounted at recommended distance from windows, stoutly resist attack, help prevent costly damage to window frames, sash, paint.

You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

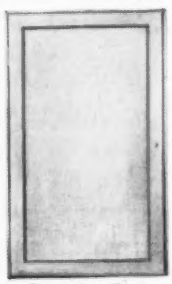
You reduce the threat of disaster. No grilles, no bars to trap your patients in a fire. No stubborn locks hinder their rescue. Exclusive Chamberlin emergency release permits instant patient removal from outside.

You cut grounds maintenance costs. Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects by pass-in.

Over the years, these savings will more than offset your original costs. Yet they're only *part* of the savings and services other hospital administrators count on every day (see right). Let our Hospital Advisory Service give you full details. Write today.

The right screen at the right cost to fit your patients' needs

Detention Type



Protection Type

Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for nonviolent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings; replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

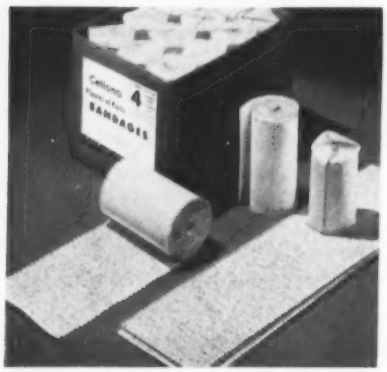
Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICH.

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Calking, All-Metal Combination Windows, Insect Screens, Building Cleaning, Tuck Pointing, and Waterproofing

What's New . . .

Cellona Plaster of Paris Bandage



A new cellular-type plaster of paris bandage has been developed with a non-dusting coating. The coating leaves no residue in the package and loose plaster is not scattered when the bandage is being handled. It saturates completely in room temperature water, in seconds, without adding salt or chemicals.

Known as Cellona Plaster of Paris Bandage, the new product leaves only a small trace of lost plaster in the water, thus giving maximum efficiency and reducing the number of thicknesses necessary to make a firm cast. It is free from acetic acid, odorless and non-irritating. It is made in all standard sizes of bandages and slabs, in slow, fast and extra fast setting types. **The Scholl Mfg. Co., Inc., Surgical Div., Dept. MH, 213 W. Schiller St., Chicago 10. (Key No. 145)**

Greaseproof Tile

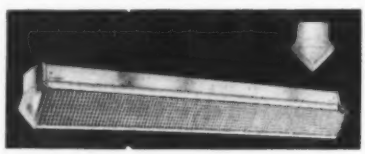
The new Vinylized Azphlex Greaseproof Tile is a low cost, dependable floor covering. It is designed to offer exceptional resistance to all kinds of greases and oils. The tighter texture gives a smooth surface that resists the wearing-in of grime and dirt. The tile is unusually flexible and is offered in twelve bright, decorative colors to blend with any modern or traditional decor. The marbleized pattern is distributed throughout the thickness of the tile so that it remains throughout its life. The new Azphlex Tile is available in standard, border and special sizes in ⅛ inch and 3/16 inch thicknesses. **Uvalde Rock Asphalt Co., Dept. MH, P. O. Box 531, San Antonio 4, Tex. (Key No. 146)**

Floor Machine

Designed especially for smaller areas, the new Johnson's Wax Special 12 is an economical floor maintenance machine. It has many of the features of the larger heavy-duty floor machines and can be used for waxing, scrubbing, shampooing rugs, sanding or buffing. It can be used conveniently under fixed furniture and in confined quarters as it is only 11 inches high. It is balanced for fast, effortless operation and has patented finger springs on brush brackets to keep the machine riding level at all times. The adjustable handle can be set to a convenient operating height and can be quickly raised to upright position for storage. A fingertip-controlled trigger switch and a wire whisker in the brush are safety features of the machine. It has a ¼ h.p. motor and quick-change attachments are available to make it an all-purpose machine. **S. C. Johnson & Son, Inc., Dept. MH, Racine, Wis. (Key No. 147)**

Corridor Lighting

A new Corridor Lighting Fixture with broad sidewise illumination has been developed for asymmetrical lighting requirements in wide halls and corridors. The brightness is well shielded lengthwise by means of 45 by 45 degree plastic Grate-Lite louvers. In a ten foot wide hall, from 5 to 20 foot candles can be uniformly distributed across the entire hall with the new unit. The new V-C-U Corridor Light is available in 4,



8 and 16 foot lengths, wired Rapid-Start, Conventional or Slimline, in one or two rows of lights. **The Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo. (Key No. 148)**

Spirit Duplicator

Up to five colors can be printed on the new Conqueror Spirit Duplicator. It produces copies face up at high speed and is the result of two years of engineering research. The machine has a number of features which make it efficient in operation, easy to use and durable. The fluid supply is visible when filling and operating through the glass insert in the plated brass tank. Maximum runs are assured through the adjustable pressure control. The master is easily attached to the cylinder through the new master clamp, calibrated for centering any sized paper. The operator can instantly raise or lower copy on paper with the new control which has a range of six inches. The new large capacity rotary feed is designed for extended runs and the machine is engineered for perfect registration. The new design is by Jean Reinecke. **The Heyer Corp., Dept. MH, 1850 S. Kostner Ave., Chicago 23. (Key No. 149)**

(Continued on page 240)

Arketex Splayed Base

A ceramic base board to be installed with wall or floor construction is available in the new Arketex Splayed Base. This attractive and strong finish provides protection of walls by preventing most movable objects from coming close enough to the walls to mar or damage them. At the same time they simplify cleaning and maintenance. The base is available in all Arketex standard colors and in a choice of shapes to meet the need. **Arketex Ceramic Corp., Dept. MH, Brazil, Ind. (Key No. 150)**

Telescoping I.V. Stand

A new idea in I.V. stands seems to have been developed in the new Polecat unit. The stand weighs only about two pounds, requires no heavy base or tripod stand, takes up only one square inch of floor space and cannot be knocked down. The stand will support up to 200 pounds of weight and requires a bare minimum of storage space.

The Polecat I.V. Stand has a spring device built into the top under a soft sponge-rubber ceiling pad. The telescoping pole is set for the ceiling height required—anything up to 10 feet 8 inches—and it is sprung into and out of position with one hand. The adjustment to the required ceiling height in any area is made just once, by extending the two telescoping sections to the proper length and locking them into position. The stand is put in place and the ceiling pad and foot, made of special non-marking rubber, hold it firmly. Hooks to hold bottles of I.V. solution surround the pole and are easily tightened for holding even heavy weights. However, even if the hooks are not tightened, bottles cannot fall since the heavier the weight, the less likely the untightened hook is to fall. Infusions can be given at different levels to two patients in adjoining beds

at the same time. When not in use, the stand is easily pushed out of the way until it can be taken out of the room. **Polecats, Inc., Dept. MH, Lyme, Conn. (Key No. 151)**

What's New . . .

Vinylite Anatomical Models

The texture of living tissues is now possible in anatomical models made of Vinylite resin-base plastisols. This practically indestructible anatomical sculpture is modeled after authentic dissections and molded in three dimensions. Students can see, touch and remove organs, tissue and other parts of the body from flexible, easy-to-clean anatomical models. The models are resistive to oxidative decay and to chipping, abrasion and scuffing. They resist attack by most chemicals and are easily washed and cleaned with a damp cloth.

Different plastisols based on Vinylite resins are used for the various organs to make them feel like real living tissue. Basic colors are pigmented in the plastisol and hand painted artwork applied by artists. The paints are also based on Vinylite resins to establish a permanent bond with the plastisol base. Zoological and botanical models are also available in the new material. The models are economically produced at competitive prices. **American Hospital Supply Corp., Dept. MH, 2020 Ridge Ave., Evanston, Ill. (Key No. 152)**

Dixie Fountain Line

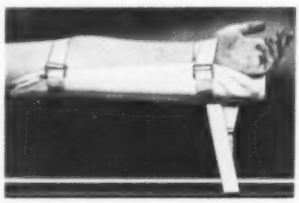
A new line of Dixie cups for soda fountain and snack shop use has been introduced. It includes fountain cups, a super-sundae dish, three types of melamine plastic holders for cups and dishes, and two heavy-duty plastic dispensers. The "super-blend" fountain cup is available in six sizes and has double-thick, machine-formed bottom for greater strength. The new melamine holders are resistant to scratching, chipping, breaking or warping and are colorfast, odorless, burnproof and quiet. The new dispensers are made of molded plastics in buff and gray and are designed to be top-loaded direct from the carton. They protect dishes from dust, dirt and handling and can be easily washed or wiped clean. **Dixie Cup Co., Dept. MH, Easton, Pa. (Key No. 153)**

Individual Lunch

Five new varieties have been added to the Heinz Individual Plate Lunch line. Developed to provide better control of food costs by providing individual servings in tins, for lunch room, cafeteria and dining service, the new dishes are made from quality ingredients and the line includes only foods with popular appeal. The new varieties are Beef Goulash, Chop Suey, Chicken Noodle Dinner, Spanish Rice and Macaroni Creole (with mushroom in tomato sauce). Already in the Individual Plate Lunch line were Beef Stew, Lamb Stew, Chicken Stew with Dumplings, Baked Beans, Spaghetti, Macaroni and Chili ConCarne. The tins are packed two dozen of one variety to the case. **H. J. Heinz Co., Dept. MH, P. O. Box 57, Pittsburgh 30, Pa. (Key No. 154)**

Arm Restraint

Developed by Marcelle McInnerny, R.N., a new Arm Restraint is available which holds the patient's arm or leg firmly yet comfortably for transfusions or intravenous feedings. The restraint has a rigid fiber base plate, contour-



shaped to fit either arm or leg, which is heavily cushioned with foam rubber for comfort. A white, snug-fitting, smooth plastic cover on the outside is removable and is easily wiped clean. It fastens with a white nylon tape zipper and white nylon straps hold the patient's arm or leg comfortably. An extra strap is available to fasten the restraint to the bed. **Hinson Manufacturing Co., Dept. MH, Waterloo, Iowa. (Key No. 155)**

One-Man Fire Engine

A one-man wheeled fire fighting unit for extinguishing large scale B and C fires is now available. The Dry Chemical Wheeled Engine has a capacity of 150 pounds and discharges free-flowing, quick-smothering Alfco Dry Chemical. The unit has a discharge range of from 20 to 25 feet, enabling the operator to move up quickly on the fire. The unit is designed to be easily wheeled, maneuvered and operated by one man. It carries the inspection and approval label of Underwriters' Laboratories, with B and C classification, according to the manufacturer. **American-LaFrance-Foamite Corp., Dept. MH, Elmira, N. Y. (Key No. 156)**

(Continued on page 244)

Spun Boltaflex

A new upholstery fabric has been developed that looks and feels like wool, is virtually stainproof, and is comfortably cool even in hot weather. Known as Spun Boltaflex, the new material combines the appearance of wool with the durability and washability of the toughest saran plastic. It may be cleaned with any kind of soap, detergent or upholstery cleaner or dry cleaned. The fibers are impervious to moisture, so cannot rot or mildew. Colors are an integral part of the saran fibers and cannot run, wear or rub off. The new material is now available in two contemporary patterns in a variety of colors. **Bolta-Saran, Inc., Dept. MH, Lawrence, Mass. (Key No. 157)**

Bactericide-Disinfectant

Diversol CX is a new bactericide-disinfectant cleaner and deodorizer. It helps control bacteria, mold and yeast and is 100 per cent soluble, stable and noncorrosive. A new formula of inorganic coloring gives the product a pink color for ready identification. The product has superior water softening and powerful penetrating action and will not stain. It is packed in 325 pound barrels, 125 pound and 25 pound drums. **The Diversey Corp., Dept. MH, 1820 Roscoe St., Chicago 13. (Key No. 158)**

Luxo Lamp

A versatile light for every hospital need is offered in the new Luxo Lamp. The height can be adjusted to any requirement at the desired intensity. A tension spring holds the lamp exactly where it is placed. When attached to the movable tiltproof stand it is excellent for use in the examining room. It can also be used with a flat base or clamp on a desk, or attached to the wall beside the patient's bed. The arms and shade together provide a radius of 45 inches, making it possible to have a con-

centrated light in any spot over a wide area. **Luxo Lamp Corp., Dept. MH, 290 Madison Ave., New York 17. (Key No. 159)**

Now...A Practical, Efficient and Economical Method of Window Replacement or Renovation

before

This photo shows the seriously-deteriorated condition of some of the wooden sash in the Hotel Hollenden, Cleveland, Ohio. Drafts and difficulty in operating the windows were sources of complaint from guests. Water leakage and excessive dirt infiltration caused considerable trouble and expense.

after

This photo shows same Hollenden window opening after old wood windows were replaced with streamlined, Rusco galvanized steel windows, complete with insulating sash. Use of Rusco insulating sash provides rain-proof, draft-free ventilation regardless of weather. Also reduces street noises, increases heating efficiency and saves fuel, and is ideal treatment for air conditioning.

Replacing or renovating windows normally involves serious disruptions in service, heavy expense and, in many cases, a temporary loss of revenue. But The F. C. Russell Company, world's largest manufacturer of metal combination windows and developer of the unique fully pre-fabricated Rusco Prime Window, has created products and methods which overcome these problems.

Rusco can now replace or renovate your worn-out or otherwise unsatisfactory windows at a substantial saving and, very likely, without taking rooms out of service for even a day!

A Typical Example: Hotel Lafayette, Buffalo, N. Y.

The Hotel Lafayette was faced with a serious situation because the old wood windows were so deteriorated that complete replacement was necessary. Photo at right shows The Lafayette as it looks with Rusco galvanized steel windows installed in place of the old windows. Manager K. A. Kelly says, "The time consumed for installation, I believe, was about two months and this was done at a time when we were running to capacity every night. During that period we did not have as much as one complaint of inconvenience to the guests. In fact, when the windows were delivered to the hotel, a floor or two floors at a time, we would place the material in the clothes press of the room and place a card on the clothes press door explaining that these were new windows to be installed for the convenience of our guests.

"Aside from the fine features of eliminating dust and dirt and doing away with the extreme draft in cold weather, our window screens were a major problem for us and with the permanent installation of screens our headache has been eliminated.

"We feel that our money was spent very wisely and we have had nothing but the finest reaction from our guests, particularly from those who have been steady patrons of the hotel for a number of years and knew only too well what conditions existed with the old windows. I can recommend these windows most highly."

WHAT RUSCO CAN DO FOR YOU!

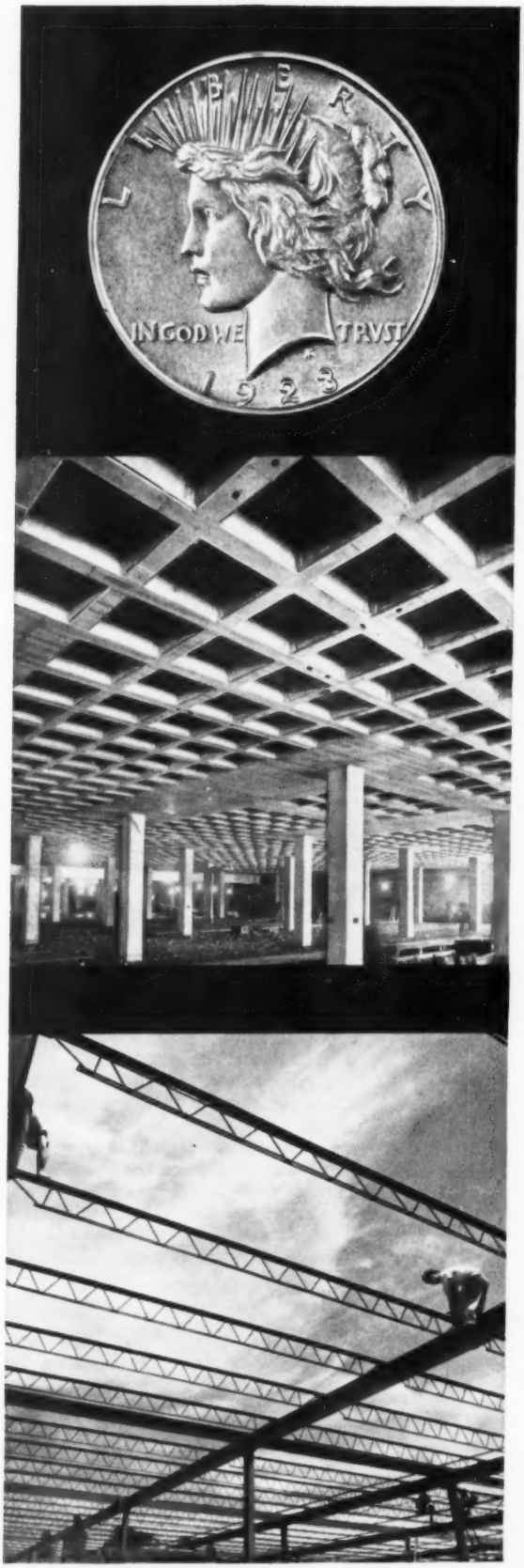
1. Complete replacement of old windows with modern, streamlined Rusco Galvanized Steel Windows complete with insulating sash. Choice of Rusco's Fiberglas or Rusco Lumite plastic year 'round screens that never have to be changed.
2. Complete replacement of old windows with Rusco Galvanized Steel single-window units. Choice of Rusco's Fiberglas or Rusco Lumite plastic screens.
3. If present windows are not too seriously deteriorated, an installation of Rusco Combination Windows to serve as the primary windows will preserve them and make window openings fully weathertight.
4. Rusco glass inserts are interchangeable and removable from inside the building. By keeping a supply of spare inserts on hand, window washing and repair of broken glass can be accomplished speedily and without any inconvenience to guests or tenants. Spare inserts are slipped into window and removed inserts taken to central point for washing or re-glazing.

RUSCO
Fully-Assembled, Ready-To-Install
GALVANIZED STEEL WINDOWS

We will be glad to have our window conditioning engineers consult with you at your convenience. Simply call or write

THE F. C. RUSSELL COMPANY

Dept. 6-MH93 • Cleveland 1, Ohio
In Canada: Toronto 13, Ontario



get big dollar

savings with Ceco's joist construction

Any way you figure it, joist construction is the most economical way to build floors and roofs. And Ceco offers two types—both fire-resistive—both engineered for economy. They are Steel Joist Construction and Meyer Steelform Concrete Joist Construction. Occupancy requirements, availability of labor and material and other factors will guide the architect and engineer in selecting the most favorable type of joist construction for each project.

Ceco concrete joist construction

Here you can expect savings over solid slab and other heavier types of concrete construction, because less steel, concrete and lumber are used . . . less labor too. Meyer steelforms are reused at a nominal rental fee.
Murphy & Mackey, architects, saved $50,000.00 by using concrete joist construction instead of solid slab in the Bishop DuBourg High School, St. Louis, Missouri.

Ceco steel joist construction

Because there is less weight in steel joist construction . . . supporting beams, columns, and footings are lighter.
The self-centering feature eliminates formwork and shores.
Architect Harry Owen Bartlett used Ceco steel joists in the design of Remington Rand's new Chicago office building to reduce column loads and effect major savings.

CECO PRE-PLANNING CONSULTATION SERVICE

Ceco product and design specialists will assist you in the application of Ceco building products at the pre-planning stage. Call your nearest Ceco office for overnight consultation service. (ceco)

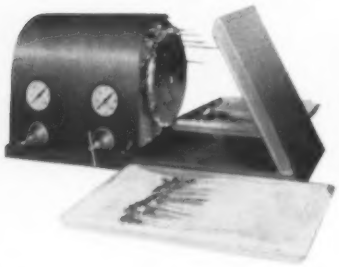
In construction products
CECO ENGINEERING
makes the big difference

CECO STEEL PRODUCTS CORPORATION

Offices, warehouses and fabricating plants in principal cities
General Offices: 5601 W. 26th St., Chicago 50, Illinois

What's New . . .

Knight Needle Cleaner



The new Knight automatic hypodermic needle cleaner can be operated efficiently by unskilled personnel and provides a speedy, thorough method of cleaning hypodermic needles. It is easily installed in a matter of minutes and is sturdily constructed for years of satisfactory service. It has been tested by months of actual hospital use and provides an efficient labor saving device. The small, compact unit requires minimum operating space and is automatic in operation. **Technical Equipment Corp., Dept. MH, 2548 W. 29th Ave., Denver 11, Colo. (Key No. 160)**

Roach Spray

A new type insecticide has been introduced for the control of cockroaches. When sprayed on surfaces known to be traveled by roaches, Pressurized Roach Spray deposits an invisible film of active ingredients having both contact and residual killing powers. The killing ingredients are forced into cracks and crevices from the pressurized container. The new spray contains Chlordane, DDT and other special chemicals, offering maximum roach control with minimum effort. It is quick and easy to use, will not stain woodwork, fabrics or painted surfaces, and is nontoxic to humans. **J. I. Holcomb Mfg. Co., Dept. MH, 1601 Barth Ave., Indianapolis 7, Ind. (Key No. 161)**

Cold Food Servers

The serving of cold or frozen foods without chipped ice is now possible with the new Tempinware Servers. A permanent eutetic refrigerant is sealed inside the inner walls of the serving dishes. Stored in a freezing compartment, the refrigerant absorbs the cold and remains frosted for as long as one hour when in use. It holds the food at a lower temperature than ice.

For serving, the Tempinware is removed from the freezer, food is placed in the insert or inter-liner and then placed in the Tempinware bowl. The containers are made in a choice of durable metals, including silver plate if desired. Each set consists of a food liner, refrigerating bowl and underliner. Where chipped ice service dishes are already available, they can be used instead of the underliner. Tempinware is designed for serving ice creams, sherbets, fruits, fish and vegetable cocktails and similar foods. **Redi Products Corp., Dept. MH, 60 N. Sierra Blvd., Pasadena 8, Calif. (Key No. 162)**

Portapatient Carrier

Even seriously ill patients can be safely moved by one nurse or attendant in the Portapatient Carrier. This hydraulic cart is designed to transport patients to and from surgery, x-ray, physical therapy or other departments of the hospital. It can be used as a receiving cart in ambulance duty where the frame is used as a litter, to permit patient to use a bed pan without being removed from traction, and for changing linens with minimum distress when patient is in traction or is seriously ill.

The carrier is made of welded tubular steel and fabric and is hydraulically raised or lowered so that the smallest

nurse can readily handle the heaviest patient unassisted and have both hands free to attend the patient. When not in use the carrier folds against the wall, requiring a minimum of storage space. **U. S. Engineering & Mfg. Co., Dept. MH, 3254 Lincoln Ave., Chicago 13. (Key No. 163)**

Steel Storage Cabinet

A "budget-designed" steel storage cabinet is offered in the new Penco Stationer. It is sturdily built of first-grade furniture steel with electrically welded frame, dust-tight reenforced doors, three point security latching, chrome handles with built-in lock and four adjustable shelves. It provides large storage capacity in only 4½ square feet of floor space. The overall size is 36 inches wide, 18 inches deep and 78 inches high with modern flush-front design. The cabinet is available in gray or office green baked-on enamel finish. **Penn Metal Corporation of Penna., Dept. MH, 50 Oregon Ave., Philadelphia 48, Pa. (Key No. 164)**

(Continued on page 248)

Slip-Resistant Floor Finish

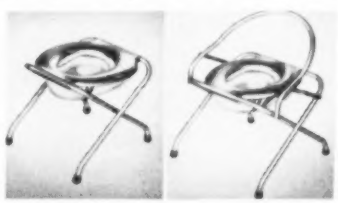
A new protective floor finish which gives a high gloss without buffing and has unusual slip-resistant qualities is offered in Gripsheen. It provides high traction on any kind of floor, including terrazzo. Gripsheen is easy to apply, dries quickly and has high wearability. Small areas may be patched without refinishing an entire surface and it blends without showing overlap marks. This water-based finish is easily maintained by damp mopping and can be removed with West Scrub Soap. **West Disinfecting Co., Dept. MH, 42-16 West St., Long Island City 1, N.Y. (Key No. 165)**

Bondex Cement Paint

A new formula is employed in the manufacture of Bondex Cement Paint for dampness control problems and Bondex Heavy Duty for serious moisture control. They offer a simple method of attractively resurfacing porous masonry surfaces while combating all degrees of moisture control problems. The Heavy Duty is an aggregate type wall coating for rejuvenating old buildings having porous masonry surfaces. It is applied with an ordinary fiber brush on interior and exterior masonry walls and penetrates the pores of the material hydraulically. When dry it gives an even sand-like finish. It can also be used by builders in treating exterior walls which will be below grade. **The Reardon Company, Dept. MH, 7501 Page Blvd., St. Louis, Mo. (Key No. 166)**

Komfort-Fold Chair

Light weight, all-aluminum comfort chairs, which are easy to handle, easy to keep clean and sanitary, and readily folded into a compact unit, are now available. Known as the Komfort-Fold Chair, they are available in two models, standard and de luxe. The de luxe model has back and arm rests for patients requiring them, and both chairs provide comfortable toilet facilities which are readily brought to the place of need. The toilet seat is of standard size and height and the protective alumilite finish



will not chip or crack. **Will Mark Company, Dept. MH, P. O. Box 4098, Valley Village, North Hollywood, Calif. (Key No. 167)**

Utmost Care

Utmost care is the essence of fine hospital service: utmost care in ministering to the patient's needs... utmost care in selecting and purchasing materials... utmost care in all phases of operation.

Utmost care must be taken, for example, to select sheets and pillow cases that meet your requirements of long wear, comfort and good appearance.

That is why so many careful buyers of sheets for so many fine hospitals prefer Utica Muslin sheets, woven with over 140 threads to the square inch (finished count).

Utica Muslin Sheets are made with the utmost care, in one of the most modern mills of its kind in all the world, to satisfy your standards of highest quality at lowest possible cost.

SHEETS AND PILLOW CASES
STEVENS
UTICA MOHAWK

UTICA SHEETS

UTICA AND MOHAWK COTTON MILLS DIVISION
J. P. STEVENS & CO., INC., STEVENS BUILDING
BROADWAY AT 41st STREET, NEW YORK 36, N. Y.

ATLANTA • BOSTON • CHICAGO • CLEVELAND • DALLAS • LOS ANGELES • PHILADELPHIA • SAN FRANCISCO • ST. LOUIS

FOR EVERY ROOM IN YOUR HOSPITAL

get a YORK room air conditioner with HEAT PUMP

YES—YEAR-ROUND PATIENT COMFORT AT THE TURN OF A WRIST! *PLUS* THE THERAPEUTIC VALUE OF A CONSTANT SOUND LEVEL AND SHUTTING OUT OF STREET NOISES!

Patients and staff alike will enjoy YORK Heat-Pump Room Air Conditioners *12 months a year!* When it's hot, York brings in *cool*, clean, filtered air. When it's chilly, just a turn of the wrist and the same York unit brings in *warm*, clean, filtered air.

Now York adapts the fabulous Heat Pump to its room air conditioners! With the Heat Pump on the job, York heats—cools—filters the air clean—removes muggy humidity—ventilates—circulates.

With day-round, year-round patient comfort—and staff comfort—so important, you'll want to do what so many other hospitals are doing. Turn to York. *And* it costs less than you may think.

Behind this great York Heat-Pump Room Air Conditioner stands the experience that built more than a half-million units. For full details, call your YORK Dealer. Or write to York Corporation, York, Pennsylvania.

when it's HOT, patients can be COOL
when it's CHILLY, patients can be WARM

SUMMER		EARLY FALL . . . LATE SPRING		LATE FALL . . . EARLY SPRING		WINTER	
It's a **hot** morning It's a **sweltering** afternoon It's a **muggy** evening	BUT patients stay comfortable—because York COOLS without chilling	It's a **chilly** morning It's a **warm** noon It's a **brisk** evening	BUT patients are comfortable—because York HEATS or COOLS at the turn of a wrist	It's a **cold** morning It's a **chilly** evening	BUT every room is comfortable—because York HEATS	You need spot heat in clinics, dispensaries, bedrooms A room is stuffy—needs ventilation with **fresh, warm air**	AND everyone's comfortable—because York HEATS, CIRCULATES, VENTILATES

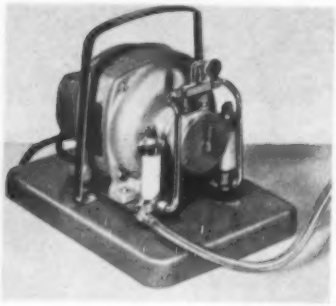
YORK AIR CONDITIONING AND REFRIGERATION

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885

York refrigeration air conditioning

What's New . . .

Suction Unit for Cast



Designed to meet the requirements of a portable pump capable of vacuumizing the Flexi-Cast Quick-Freeze Immobilizer, the new Picker Suction Unit may be used in the emergency room, ambulance equipped with 110 volts, x-ray department or patient's room. It is equipped with a 1/6 h.p. motor and is rubber mounted to minimize vibration. The rotary compressor produces not less than ½ cubic foot negative pressure per minute. The suction control valve is mounted above the rotary compressor and is easily operated. Two filters exclude dust and oil vapors from the system. **Picker X-Ray Corp., Dept. MH, 25 S. Broadway, White Plains, N.Y. (Key No. 168)**

Ice Flake Machine

Six new models of the Scotsman Super-Flaker ice machine have been put on the market. The 1953 line has many engineering changes and modifications. Two completely new models have increased capacity designed to produce 1000 pounds of ice per day. Machines are available in either completely automatic storage-type unit or the continuous-flow type. The units feature low operating cost, and the new patented freezing and flaking mechanism is simple and trouble-free. New features include a completely sealed refrigeration system, safety cut-off, heavy duty self-aligning worm bearing and new type sealed insulation. **American Gas Machine Co., Dept. MH, Albert Lea, Minn. (Key No. 169)**

Insect Killing Light

The Bug Bulb has been devised as a new concept for killing common insects. The bulb is screwed into an ordinary lamp, Bug-Bulb tablets are dropped in, the lamp switched on and the operation is then automatic. It is a simple, inexpensive operation, long lasting and clean. It can be used in indoor spaces measuring 3000 cubic feet or less and can be moved from room to room as needed to destroy insects. **American Aerovap Inc., Dept. MH, 170 W. 74th St., New York 23. (Key No. 170)**

Wall Covering Designs

Fifty-four attractive new designs in Varlar Stainproof Wall Covering are now available. This durable wall covering is resistant to grease, dirt, crayon, oil, ink and other stains and is easily cleaned with soap and water. It is as easily applied as wallpaper and requires a minimum of maintenance.

The new designs include floral, stylized and pictorial patterns suitable for use in patient rooms, solariums, reception areas, waiting rooms and other sections of the hospital as well as in nurses' homes. **United Wallpaper Inc., Dept. MH, Merchandise Mart, Chicago 54. (Key No. 171)**

Ozone Deodorizer

An attractive, inexpensive lamp which can be plugged in and pinned-up in any desired location, provides odor control for areas up to 100 cubic feet. More lamps can be used for larger areas. It is a professionally designed and constructed electric fixture, equipped with a General Electric ozone lamp and auxiliary parts. It has chrome aluminum finish and parts have Underwriters Lab-

oratories approval, according to the manufacturer.

The lamp destroys offensive odors instantly and can be used in patients' rooms, utility rooms, kitchens, bathrooms, rest rooms, cellars and any other area where odor control is desirable. **Broadwax Fluorescent Co., Dept. MH, 443 Glenmore Ave., Brooklyn 7, N. Y. (Key No. 172)**

Fearless Dishwasher

The new Fearless Model 44 Dishwasher has been designed for average-sized institutions. The exclusive Dyna-Wash action is provided by a vibrationless motor-pump unit. The Power-Rinse spray for rinsing interiors of cups, glasses and bowls which are placed upside down in the racks is another feature of the new model.

The unit is a door type dishwashing machine which sprays heated detergent solution upon dishes in racks from above and below. After washing, fresh rinse water is sprayed from above and below. The operations can be controlled manually or automatically. The machine is designed for 20 by 20 inch racks. **Fearless Dishwasher Co., Inc., Dept. MH, 175 Colvin St., Rochester 2, N. Y. (Key No. 173)**

(Continued on page 252)

Refrigerated Dessert Display

Cafeterias, lunchrooms and soda fountains in hospitals can be equipped with a refrigerated dessert display cabinet. The new Frigidessert unit provides 11 square feet of refrigerated display for desserts. It is a self-contained unit with the compresor built into the stainless steel showcase. It operates by being plugged into any standard electric outlet. **Stainless Food Equipment Co., Dept. MH, 272 New St., Newark 3, N.J. (Key No. 174)**

Hilton's Oyster Stew

A canned oyster stew with a per serving cost of only 14 cents, is now on the market. The new product is quickly prepared for serving by simply adding milk and heating. It is processed to preserve all of the nutritional values of the oyster, including the essential vitamins, high protein value and glycogen in readily digestible form, as well as other nutrients. The new canned product is supplied in 3 pound 3 ounce cans, packed six cans to the case. It is also available in 8 ounce individual serving cans, packed 24 to the case. **Hilton Seafood Co., Dept. MH, Peoples Bldg., Seattle, Wash. (Key No. 175)**

Gas Fired Oven

The new sectional gas fired Martin cabinet ovens for baking and roasting are indirect heated. The indirect recirculating heating system provides uniform heat distribution, good results on hearth goods baked with steam and unusually low gas operating cost. Continuous baking or roasting is possible with no waiting between batches.

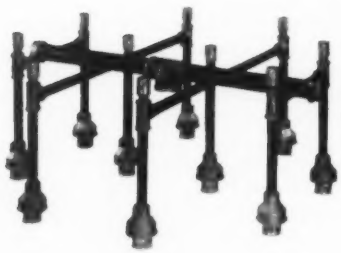
Both baking and roasting chambers are identical except for inside height. Instruments and flues are located in the right hand ventilated section, separated from the heat by four inches of insulation. All incoming combustion air is admitted at the rear and front, permit-

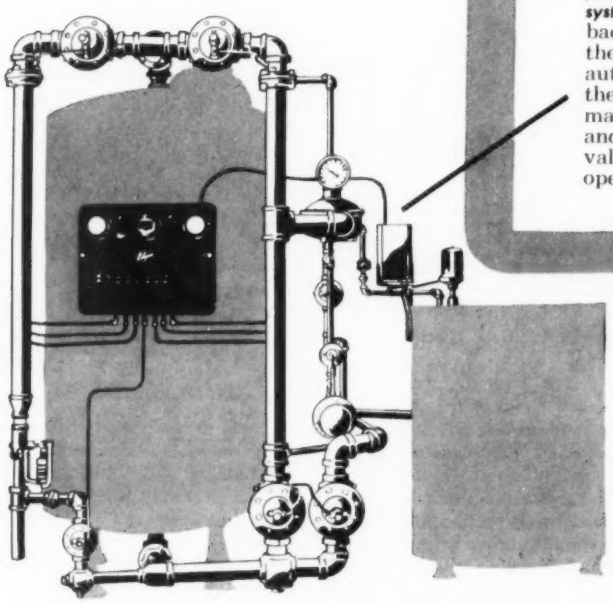
ting multiple oven installations to be banked side by side. **Martin Oven Co., Inc., Dept. MH, Rochester 10, N. Y. (Key No. 176)**

ELGIN OFFERS *3 methods* FOR GETTING

BETTER SERVICE FROM YOUR PRESENT WATER SOFTENER

If your present water softener demands too many man-hours for regeneration, if salt costs are excessive, if you are not getting all the soft water you need, Elgin engineers can offer you three easy inexpensive ways to make your equipment do a better, more efficient job!





First Method Believe it or not, you can get ***3 to 10 times more soft water*** simply by refilling your present water softener with one of the new high-capacity Elgin zeolites! The new Elgin softening materials require less frequent regeneration, save both time and salt costs, and are available for immediate delivery.

Second Method The exclusive and ingenious Elgin "Double Check" manifold system makes possible utilization of far more zeolite—with resultant output increases—in your present softening equipment. Designed for installation in any water softening unit, the "Double Check" system prevents loss of zeolite, increases efficiency of brining and backwashing, and can ***increase softening capacity by as much as 44%***. This, remember, is a gain in efficiency beyond the basic increase provided by high-capacity zeolite!

Third Method Finally, you can ***convert your present equipment into a completely automatic softening system*** —a self-operating, self-contained unit that backwashes, brines the zeolite, rinses it, and puts the regenerated softener back into service—all automatically! Automatic control—operated by the Elgin "nerve center" pilot—eliminates human errors, increases efficiency to a new high, and perhaps most important of all, saves many valuable man-hours required with manually operated equipment.

Get full details about modernizing your present water softening equipment. Let us put you in touch with the Elgin engineer nearest you.

ELGIN
SINCE 1908
WATER CONDITIONING
FOR EVERY NEED

Representatives in Principal Cities

ELGIN SOFTENER CORPORATION, 144 N. Grove Ave., Elgin, Ill.

In Canada: G. F. Sterne & Sons, Ltd., Brantford, Ontario

What's New . . .

Pharmaceuticals

Depo-Cer-O-Cillin

Depo-Cer-O-Cillin is a brand of chloroprocaine penicillin O which has proved to be less allergenic than penicillin G. The range of antibacterial activity and blood concentrations following intramuscular injections are similar to penicillin G. It is packaged 1,500,000 units in a serile vial. In the dry form it is stable for 36 months at room temperature. **The Upjohn Company, Dept. MH, Kalamazoo, Mich. (Key No. 177)**

Apolamine

Apolamine is a new antiemetic compound which has been found effective in the treatment of nausea and vomiting in pregnant women. Clinical investigation indicates that the condition is controlled in a short time with Apolamine. The product is supplied in bottles of 100 tablets. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 178)**

Repackaging

Labels and packaging of Lakeside Laboratories products have been redesigned. This has been done to provide pharmacists with attractive, easily identified units. The new design was created by Gilbert Gettleman, industrial designer, and features multi-color combinations and clarity of product names. **Lakeside Laboratories, Dept. MH, 1707 E. North Ave., Milwaukee 2, Wis. (Key No. 179)**

Plavolex

Plavolex Dextran Solution is now available to physicians. It is a superrefined dextran solution, 6 per cent, for intravenous injection in the treatment of shock. It is free from serum-hepatitis virus. Dextran was first used as a substitute for human blood plasma in Sweden during World War II and has been under extensive tests for several years. Plavolex is available in bottles of 500 cc., ready for use without reconstitution. **Wyeth Laboratories, Dept. MH, 1401 Walnut St., Philadelphia 2, Pa. (Key No. 180)**

Sombulex

Sombulex is a new short-acting barbiturate introduced as a means of inducing sleep. It is rapidly and completely metabolized, leaving the patient free of barbiturate hangover effect. Each tablet contains 4 grains of N-methyl cyclohexenyl methyl barbituric acid. The tablets are supplied in bottles of 100. **Schenley Laboratories, Inc., Dept. MH, Lawrenceburg, Ind. (Key No. 181)**

Product Literature

• The complete line of CHF tables manufactured by The Chicago Hardware Foundry Co., North Chicago, Ill., is shown in a new catalog recently issued. Entitled **"Tables of Distinction,"** the catalog is a companion piece to the recent catalog, "Stools of Distinction," issued by the company. Color is used throughout the catalog and indicates the many different color combinations that are possible with the cast iron porcelain enamel bases and the new Sanite color finished columns. In addition to information on the new Flare Design cast construction table base, tables with a variety of metal finishes and pedestal bases, there is a section devoted to sectional tables with seats attached. **(Key No. 182)**

• Complete information on modern surgical lighting is given in the new illustrated catalog, **"Light for Surgery,"** issued by Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis. Features of the new Surg-o-beam are discussed. There are sketches of engineering details, and all equipment is pictured. **(Key No. 183)**

• A new line of suspended space heaters for use with any type of gas fuel is discussed in **Bulletin No. 543** issued by Dravo Corporation, Heating Dept., 1203 Dravo Bldg., Pittsburgh 22, Pa. The 6 page folder gives complete specification data and full explanations of how the new heaters can be used for heating and ventilating. **(Key No. 184)**

• A complete new **catalog** in full color has recently been released by Everest & Jennings, 761 N. Highland Ave., Los Angeles 38, Calif. Improvements and additions to the E & J line of folding metal wheel chairs, walkers and other invalid aids are described. The line includes more than 150 chair models designed to handle every need. **(Key No. 185)**

• **"Food Service Facilities"** is the title of a planning booklet issued by J. E. Stephens Associates, Inc., 320 W. Lafayette Blvd., Detroit 26, Mich. Twenty-four pages of sketches and photographs show carefully planned facilities for the storage, preparation and serving of food in hospitals with up to 5000 patients and employes. In some instances, overall sizes of the area and the number of persons served are stated, with the thought that this information might prove helpful in the first preliminary planning of space requirements. J. E. Stephens Associates does not sell equipment but offers a complete Engineering Service for planning. In addition to the information on hospital food service facilities, the booklet has sections on universities, schools, clubs and industrial cafeterias. **(Key No. 186)**

(Continued on page 256)

• **"Popular Year-Round Turkey Recipes"** for institutions are given in a new booklet issued by the National Turkey Federation, Mount Morris, Ill. The 16 page booklet discusses turkey as "a holiday meat in everyday demand" and offers many helpful suggestions for menu variations. **(Key No. 187)**

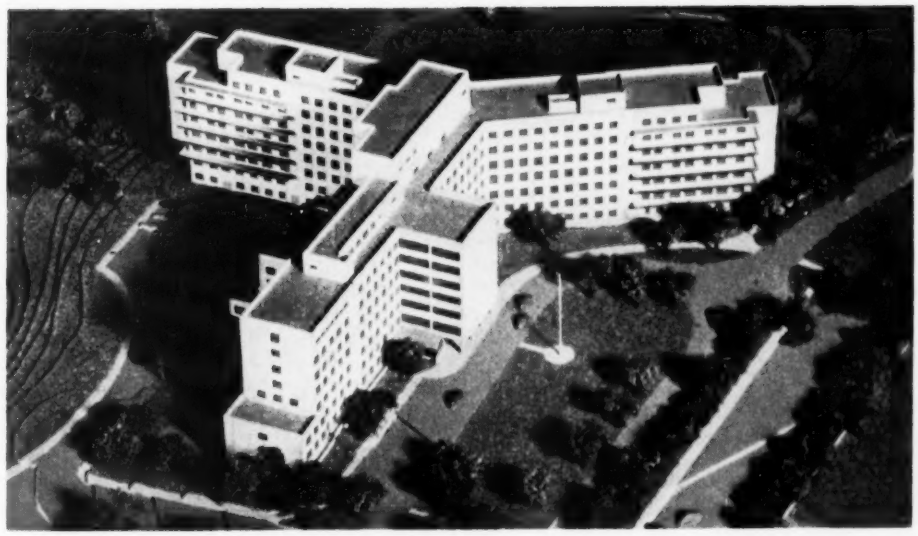
• Gas and dual-fuel firing for heating, processing and power is discussed in a new 4 page folder, **Form 2359,** printed in three colors, and issued by Iron Fireman Mfg. Co., 3170 W. 106th St., Cleveland 11, Ohio. The folder discusses the advantages of zone fire control for low start and modulated firing permitted by the Iron Fireman vertical gas burner, ring-type burners designed for intermediate and high pressure gas, and the recently announced dual fuel (gas and oil) package unit. **(Key No. 188)**

• A new publication for magnetic sound movie makers is being published by Bell & Howell Co., 7100 McCormick Rd., Chicago 45. Entitled **"Pioneer Tracks,"** the new bulletin will be edited and published by Bell and Howell to serve as a medium for the exchange of ideas and experiences in magnetic sound recording. The first issue appeared in April. **(Key No. 189)**

• The complete 216 page catalog of Clay-Adams instruments, laboratory specialties and visual aids for medicine and biology is now available from Clay Adams Company, Inc., 141 E. 25th St., New York 10. **Catalog 105** is printed in color and black and white and illustrates the products described. It is carefully indexed by product name and catalog number and includes such items as centrifuges, blood testing instruments, microscopy supplies, chemistry supplies, surgical and dissecting instruments, hospital and surgical specialities, catheters and drains, anatomical models, charts and many other items. **(Key No. 190)**

• **The Lawler Line of Thermostatic Control Valves** is described and illustrated in **C-5 Condensed Catalog** released by Lawler Automatic Controls, Inc., 453 N. MacQuesten Pkwy., Mount Vernon, N. Y. **(Key No. 191)**

• Hospitals with organized occupational therapy departments will be interested in the new **Catalog and Parts Manual** on the Dyna-Kiln recently released by the L and L Manufacturing Co., Chester, Pa. These trouble-free electric kilns for firing ceramic ware should be ideal for use in occupational therapy in chronic disease hospitals, veterans hospitals, tuberculosis hospitals, mental hospitals and similar institutions. Detailed information on the construction and operation of the kilns is given in the manual. **(Key No. 192)**



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What's New . . .

• Virtually all information necessary for specifying builders hardware for new hospital construction, or renovation of existing hospitals, is contained in a new booklet on **"Yale Aluminum Hospital Hardware,"** described as "opening a new design corridor to harmonizing beauty and service." The booklet was prepared by The Yale & Towne Manufacturing Co., Stamford, Conn., for hospital administrators, architects and contractors. It gives detailed descriptive data with illustrations of the new line of Yale Aluminum Hardware with particular reference to hospital applications, as well as information on Yale mortise locks and latches, Yale compact door closers, Yale combination locker locks and padlocks, Yale door, drawer and cabinet locks and Yale pin tumbler padlocks. **(Key No. 193)**

• Complete information on **"Sealweld Coffee Urns"** is given in a new illustrated handbook issued by S. Blickman, Inc., Weehawken, N. J. Detailed specifications on all urns, from single units to large 3-piece institutional batteries, are given together with sizes and roughing-in dimensions. The book presents an explanation of the "Sealweld" process, including illustrations of the construction process. **(Key No. 194)**

• **"IBM Accounts Receivable for Medical Clinics"** is the title of a new booklet published by International Business Machines Corp., 590 Madison Ave., New York 22. The booklet points out ways that mechanized accounting procedures can save time in medical clinics while providing useful statistics and tables of experience. **(Key No. 195)**

• A new 48 page **Sanitation Products Catalog** has recently been published by Huntingfon Laboratories, Inc., Huntington, Ind. Complete information on each product manufactured by the company for sanitation and maintenance, and data on the company's laboratory research and product control procedures are included in the new catalog. **(Key No. 196)**

• The sixth edition of the floor repair and maintenance manual published by the Federal Varnish Division, Enterprise Paint Co., Ashland Ave. at 29th St., Chicago 8, is now available. Entitled **"What to Use on Floors . . . And How to Use It,"** the 48 page booklet discusses new maintenance technics and applications for the care of all types of flooring, including asphalt and rubber tile, linoleum, concrete, cork, terrazzo, magnesite, marble, Masonite, Terrazzine and Travertine surfaces. **(Key No. 197)**

THIS COUPON is provided for your convenience in requesting additional information.

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- ☐ 140 White Onex-Seal
- ☐ 141 ENT-Oral Surgery Unit
- ☐ 142 Diagnostic X-Ray Tubes
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- ☐ 144 High Temperature Tape
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- ☐ 146 Greaseproof Tile
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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Suppliers' News

Clarke Sanding Machine Co., Muskegon, Mich. manufacturer and distributor of maintenance machines, announces opening of a modern branch office at **4711 W. Washington Blvd., Los Angeles, Calif.,** with complete service and repair facilities in addition to sales.

Consolidated Machine Corp. is the new name of the manufacturer of precision instruments, autoclaves and sterilizers at **39 Sudbury St., Boston 14, Mass.,** formerly known as **William Barnstead Engineering.**

Davis & Geck, a unit of American Cyanamid Company and manufacturer of surgical sutures and specialties, announces the dedication of a new plant on **Casper St., Danbury, Conn.** The executive and office staff will be located in the new plant as of August 31 with the production being moved from **57 Willoughby St., Brooklyn, N.Y.,** over a period of months.

Hospital Supply & Watters Labs., Inc., 155 E. 23rd St., New York 10, manufacturer and distributor of hospital and laboratory supplies and equipment, announces change of company name and address to **The Hospital Supply Co., Inc., 432 Fourth Ave., New York 16.**

Johnson Service Co., 507 E. Michigan St., Milwaukee 2, Wis., manufacturer of temperature and air conditioning controls, announces the opening of a new branch office at **La Crosse, Wis.** to serve the La Crosse and Eau Claire areas in Wisconsin and the Minnesota region surrounding Winona.

Wolf X-Ray Products, Inc., manufacturer and distributor of x-ray supplies and equipment, announces change of address from **59 Bank St., New York 14,** to **93 Underhill Ave., Brooklyn 38, N. Y.**

Printed in U.S.A.

"VARICK" LOTION — The refreshing skin conditioner and massage lotion that far surpasses alcohol in therapeutic value.

MEDICINE CARD RACKS For orderly storage and use of Meinecke Colored Medicine Cards — a great time and space saver.

DIET CARDS and CARD HOLDERS provide easy identification since a different color is used for every type of diet.

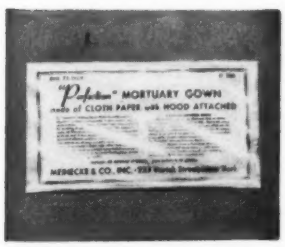
STERILWRAPS — The revolutionary wrapping technique for sterile packs that saves time, saves space, and reduces costs.

"HASSETT" SAFETY BELTS — Allow full freedom of movement, yet prevent mildly delirious patients from falling out of bed.

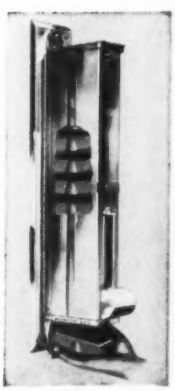
HAEMO - SOL — The original labor-saving no-scrub cleaner for laboratory glassware, surgical apparatus and surgical instruments.

METAL MEDICINE GLASS COVERS — designed with spring clips for holding colored medicine cards, also used as pill trays.

MEDICINE TRAY SETS — These are available in various sizes and styles to facilitate the proper dispensing of medicine.



MORTUARY GOWNS — made of tough cloth paper with full hood attached.—"Perfection" gowns save linen, laundry work and labor.



"STERLING" BRUSH DISPENSER automatically dispenses hand brushes, at same time insuring maximum sterility.

"VARICK" — The drainage bottle rack that hooks on bed rail and holds standard 1-gallon bottle neatly under the bed.

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● Ready for occupancy in November will be a notable addition to Manhattan's fabulous skyline—the twenty-six story, fourteen million dollar 99 PARK AVENUE BUILDING. Its special claim to distinction will not be its size nor its cost but the die-pressed, gray toned aluminum wall and window panels which will enclose it. The 1800 panels, installed from within the structure, are two stories high and each features a geometrical pattern and two reversible windows set with heat-absorbent glass. Below ground will be a large garage for tenants' cars and in a sub-basement will be storage space for tenants' records. The building will be completely air-conditioned and equipped with venetian blinds for temperature and light control. In it, as in thousands of other high ranking buildings, efficient, economical and enduring SLOAN *Flush* VALVES will be installed throughout—more proof of preference that explains why . . .

***more* SLOAN *Flush* VALVES**
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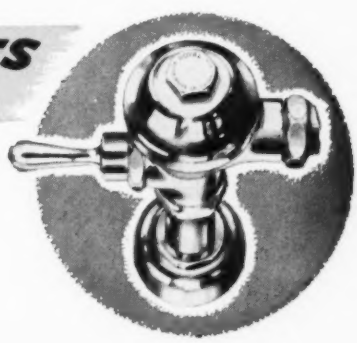

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

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